IDAHO DEPARTMENT OF HEALTH & WELFARE

DEVELOPMENTAL DISABILITIES AGENCY CHOICE FORM

As the DDA provider, **Children's Therapy Place**,
DD Agency Name

I agree to provide services to _____.
Child's Name

I understand that I am required to follow the plan of service as written, and agree to provide the following services:

_____

_____

_____

_____

_____ _____
Signature of Agency Representative, Title *Date*

_____ _____
Signature of Parent or Legal Guardian *Date*

Revised: August 2011