**Name and address of the ADRC here or on letterhead**

**Member’s Name**

**Member’s Address**

**Date**

**Dear Applicant**

**Before we can refer you for a full assessment for the Elderly and Disabled Waiver Program (EDWP), the program you requested to provide help at home, you need to choose a case management agency. Please circle or mark an X beside the case management agency of your choice below. Please sign and date your choice and return it to us in the enclosed envelope. After we receive your choice, we will contact your chosen case management agency to request an assessment in your home to determine if you meet all the requirements for the program. They will contact you to schedule the assessment after the receipt of this completed form.**

**Thanks for returning your choice to us promptly.**

***Your Aging and Disability Resource Connection***

|  |
| --- |
| **Below are the case management agencies that serve       County, your county of residence, for the EDWP. Please mark your choice by circling the name of the agency or marking an X next to it.** **Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Your Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****If not signed by the applicant, your relationship to the applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*****Return this letter with your choice indicated above in the enclosed return envelope. Thank you!*** |

|  |
| --- |
| **For ADRC Use Only:****Date received :****Notes:** |