TEXAS
Health and Human Services

Form 6510
August 2010-E

Deaf Blind with Multiple Disabilities (DBMD)

Decline of Offer for DBMD Program Enrollment

Name of Applicant		Area Code and Telephone No.
Mailing Address (Street, City, State, ZIP Code)		Medicaid No.
Name of Legally Authorized Representative (LAR) (if applicable)		Applicant's Date of Birth
DBMD Provider Agency	DBMD Provider Contact Name	Contact Area Code and Telephone No.
Vendor No.	DBMD Region	

I have received information about the DBMD Program, which provides individualized services to people who are deaf blind with additional disabilities. The DBMD Program services have been explained to my satisfaction.

I decline the offer to participate in DBMD Program services because:

I understand that by declining the offer to participate in the DBMD Program, my name will be removed from the DBMD Interest List. I also understand that, should I wish my name to be placed back on the DBMD Interest List, I must call 1-877-438-5658 to request registration on the DBMD Interest List.

_____ _____

Signature – Applicant/LAR Date

_____ _____

Signature – DBMD Provider Agency Representative Date