



(Individual's Name and Address)

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Community Based Alternatives
Application Acknowledgement

Individual's Name	Responsible Party's Name
Mailing Address (Street, City, State, ZIP)	Area Code and Telephone No.
<input type="checkbox"/> Yes, I would like to apply for Community Based Alternatives services. Please contact me to schedule an appointment to determine eligibility. <input type="checkbox"/> No, I am no longer interested in Community Based Alternatives services. Please remove my name from the interest list. <input type="checkbox"/> I am not interested in Community Based Alternatives services at this time, but would like my name to be returned to the bottom of the Community Based Alternatives interest list so that I may be contacted again in the future.	
<p>This form must be completed and returned to the Department of Aging and Disability Services contact person listed below no later than</p> <p>If the form is not returned by this date, your name will be removed from the interest list and no further action will be taken. Should this occur, you may request that your name be placed back at the bottom of the Community Based Alternatives interest list.</p>	

Signature—Individual/Responsible Party

Date

Please return this form to your assigned case manager:

Case Manager Name	Area Code and Telephone No.
Mailing Address (Street, City, State, ZIP)	Fax No.