



SECONDARY FREEDOM OF CHOICE  
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION  
Customized Community Supports - Group Service  
BERNALILLO COUNTY

Date: 04/02/2026

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DD Waiver Participant Name: \_\_\_\_\_

Dear Waiver Participant,

The Center for Medicare and Medicaid Services require that all waiver participants be afforded the right to select and obtain services from qualified providers approved by the Developmental Disabilities Supports Division (DDSD) for Home and Community Based Waivers. **Customized Community Supports - Group** Services, in **BERNALILLO** County, are available to you through the following:

_____	Best Life Caregiving Solutions LLC	(505) 607-8836
_____	Better Life Adult Living, Inc.	(505) 269-6930
_____	Bright Horizons, Inc.	(505) 765-1700
_____	Bright Light Homes LLC	(505) 210-1445
_____	Expressions Unlimited, Co.	(505) 362-2793
_____	Great Livin', LLC	(505) 246-6971
_____	Inclusive&Empowering Living Homes LLC	(505) 353-1153
_____	Lifefridge Supported Living LLC	(470) 461-7149
_____	Mandy's Special Farm dba Mandy's	(505) 503-1141
_____	Maxcare, Inc.	(505) 271-2433
_____	The New Beginnings, LLC	(505) 797-3359



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**This form needs to be signed and dated by the Waiver Participant or Legal Representative.**

DD Waiver Participant Name: \_\_\_\_\_

I have selected the named provider below based on a review of all qualified providers listed on the Secondary Freedom of Choice approved by DDSD to provide **Customized Community Supports - Group** Services, in **BERNALILLO** County.

Name of Selected Provider: \_\_\_\_\_

\_\_\_\_\_  
Waiver Participant Signature                      Date

\_\_\_\_\_  
Legal Representative Signature                      Date

\_\_\_\_\_  
Waiver Participant Printed Name

\_\_\_\_\_  
Legal Representative Printed Name

\_\_\_\_\_  
Last Four Digits of Waiver Participant  
Social Security Number

\_\_\_\_\_  
Legal Representative Telephone Number

\_\_\_\_\_  
Waiver Participant Address

\_\_\_\_\_  
City, State, Zip