



SECONDARY FREEDOM OF CHOICE
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
Speech Therapy Service
BERNALILLO COUNTY

Date: 05/21/2026

Page 1 of 2

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. **Speech Therapy Services**, in **BERNALILLO** County, are available to you through the following:

_____ Accentuate the Positive	(505) 515-0957
_____ Anna Ferris Vargas, MS, CCC-SLP	(505) 400-0249
_____ Autism Specialists LLC	(505) 429-2832
_____ Communication Therapy Services LLC	(505) 238-5370
_____ Inclusive Speech Therapy LLC	(505) 710-3833
_____ Let's Communicate, LLC	(505) 280-3521
_____ Lisa Sisneros Brow Speech-Language Pathologist, LLC	(505) 797-1952
_____ Molly L. Katona LLC	(505) 595-2664
_____ New Mexico Speech Therapy LLC	(845) 283-4644
_____ Pediatric Therapy Inc.	(505) 620-0541
_____ Practical Therapy, Inc.	(505) 980-9477



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Page 2 of 2

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 **Speech Therapy** 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