



SECONDARY FREEDOM OF CHOICE
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION
Occupational Therapy Service
DONA ANA COUNTY

Date: 05/21/2026

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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. **Occupational Therapy** Services, in **DONA ANA** County, are available to you through the following:

_____ Milagro De Vida Community Service, L.L.C.

(575) 644-6306



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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 **Occupational Therapy** Services, in **DONA ANA** 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