**Bulletin Title: AMENDED Updated Process for Consumer Choice Form Transfer Requests**
**Bulletin ID: 154 A**
**Issued Date: September 5, 2025**
**Effective Date: July 1, 2025**

On March 25, 2025, the Department of Behavioral Health (DBH) published Bulletin 134: Changes to Consumer/Client Enrollment and Service Authorization Requirements, which changed the process for providers to enroll DBH consumers and clients in care and to receive authorization and payment for services.

DBH originally published Bulletin 154 on July 1, 2025 to update the Consumer Choice Transfer process to align with the Community Support supplemental units request and authorization process to ensure an efficient submission process. DBH is publishing this updated bulletin to clarify the provider's responsibility in completing the Consumer Choice Form. All updated language is denoted in yellow highlights. Please note the following:

1. Effective July 1, 2025, all transfer requests require signatures from both the transferring provider and the accepting provider. Providers must collaborate to ensure a smooth transition of consumers including obtaining client signatures and providing medical records (*with consent*). Both the transferring and receiving provider must work jointly to ensure that representatives of both providers sign the Consumer Choice Form. It is not the responsibility or role of the consumer to request or facilitate signatures from either provider on the Consumer Choice Form.

2. DBH ***will not*** approve transfer requests that do not include both the transferring provider and the accepting provider's signatures to authenticate the consumer's choice to transfer providers.

3. A consumer must be enrolled with the Core Service Agency prior to submitting the authorization request.

4. All other requirements for submission of the Consumer Choice Form remain unchanged.

Please direct any questions to your assigned Provider Relations Specialist.

Attachments:

Consumer Choice Form – Adult
Consumer Choice Form – Youth
Consumer Choice Form - Spanish

**GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH**

## Mental Health Rehabilitation Services (MHRS) Core Service Agency
## Consumer Choice Form Adult

The following MHRS Core Service Agencies have been identified as being available to enroll you. Please review the list carefully, ask questions, and make an informed decision as to which Core Service Agency you are choosing to provide your services.

**Enrollment:**
I, _____, by completing this form, am indicating my choice of the MHRS Core Service Agency in which I would like to receive services.

**MHRS Core Service Agency** _____

**Transfer:** I am currently enrolled in a MHRS Core Service Agency and am requesting to transfer to a new MHRS Core Service Agency. My selection is noted below:

**Current MHRS Core Service Agency:** _____ **New MHRS Core Service Agency** _____.

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**Disenrollment:** I am requesting to be disenrolled from services from _____.

**Reason for disenrollment:** _____.

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By signing below, I assert that I have made this choice of my own free will and that there has been no pressure or coercion involved with me making this decision.

_____ Consumer's Name (Printed)

_____ Date

_____ Consumer's Address

_____ City/State/Zip Code

_____ Consumer's Phone Number

_____ Consumer's Date of Birth

_____ Consumer's Signature

_____ Consumer's Social Security Number

_____ Medicaid Number

**For Provider Only:**

I, _____, have witnessed the consumer declare which MHRS Core Service Agency they have elected to be enrolled without my encouragement, coercion, inducements and promises of services or transactions that are monetary nature.

_____ Initiating Supervising Clinician's NPI #:

_____ Staff Initiating Transfer NPI#/Provider Signature/Role/Date

_____ ***Releasing*** Supervising Clinician's NPI #:

_____ Staff ***Releasing*** Transfer NPI#/Provider

**GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH**

## Mental Health Rehabilitation Services (MHRS) Core Service Agency
## Consumer Choice Form Child & Youth

The following MHRS Core Service Agencies have been identified as being available to enroll you. Please review the list carefully, ask questions, and make an informed decision as to which Core Service Agency you choose to provide your services.

**Enrollment:**

I, _____, by completing this form, am indicating my choice for my child of the MHRS Core Service Agency in which I would like to receive services.

**MHRS Core Service Agency** _____

**Transfer:** My child/youth is currently enrolled in a MHRS Core Service Agency and am requesting to transfer to a new MHRS Core Service Agency. My selection is noted below:

**Current MHRS Core Service Agency:** _____ **New MHRS Core Service Agency** _____.

**Disenrollment:** I am requesting that my child/youth be disenrolled from services from _____.
**Reason for disenrollment:** _____.

By signing below, I assert that I have made this choice on behalf of my child/youth of my own free will and that there has been no pressure or coercion involved with me making this decision.

_____ Child/Youth's Name (Printed)

_____ Date

_____ Child/Youth's Address

_____ City/State/Zip Code

_____ Parent/Guardian's Phone Number

_____ Child's Date of Birth

_____ Parent/Guardian's Signature

_____ Child's Social Security Number

_____ Medicaid Number

**For Provider Only:**

I, _____, have witnessed the consumer declare which MHRS Core Service Agency they have elected to be enrolled without my encouragement, coercion, inducements and promises of services or transactions that are monetary nature.

_____ Initiating Supervising Clinician's NPI #:

_____ Staff Initiating Transfer's NPI/Provider Signature/Role/Date

_____ ***Releasing*** Supervising Clinician's NPI #:

_____ Staff ***Releasing*** Transfer NPI/Provider Signature/Role/Date

**DEPARTAMENTO DE SALUD CONDUCTUAL DEL GOBIERNO DEL DISTRITO DE COLUMBIA**

**Agencia de Servicios Básicos de Servicios de Rehabilitación de Salud Mental (MHRS, por sus siglas en inglés)**

**Formulario de Elección del Consumidor Niño y Joven**

Las siguientes Agencias de Servicios Básicos de MHRS han sido identificadas como disponibles para inscribirlo. Revise la lista cuidadosamente, haga preguntas y tome una decisión informada sobre qué agencia de servicios básicos elige para brindar sus servicios.

**Inscripción:**

Yo _____, al completar este formulario, estoy indicando mi elección para mi hijo de la Agencia de Servicios Básicos de MHRS en la que me gustaría recibir servicios.

**Agencia de Servicios Básicos de MHRS** _____

**Transferencia:** Mi hijo/joven está actualmente inscrito en una Agencia de Servicios Básicos de MHRS y estoy solicitando transferirse a una nueva Agencia de Servicios Básicos de MHRS. Mi selección se anota a continuación:

**Agencia de Servicios Básicos de MHRS actual:** _____

**Nueva Agencia de Servicios Básicos de MHRS** _____

**Cancelación de la inscripción:** Estoy solicitando que mi hijo/joven sea desafiliado de los servicios a partir de _____.

**Motivo de la cancelación de la inscripción:** _____.

Al firmar a continuación, afirmo que he tomado esta decisión en nombre de mi hijo/joven por mi propia voluntad y que no ha habido presión ni coerción involucrada en que yo tome esta decisión.

_____ Nombre del niño/joven (en letra de imprenta)

_____ Fecha

_____ Dirección del niño/joven

_____ Ciudad/Estado/Código Postal

_____ Número de teléfono del padre/tutor

_____ Fecha de nacimiento del niño

_____ Firma del padre/tutor

_____ Número de Seguro Social del niño

_____ Número de Medicaid

**For Provider Only:**

I, _____, have witnessed the consumer declare which MHRS Core Service Agency they have elected to be enrolled without my encouragement, coercion, inducements and promises of services or transactions that are monetary nature.

_____ Supervisión iniciador del NPI del médico #::

_____ Personal que inicia la transferencia NPI#/Firma/Función/Fecha del proveedor

_____ Supervisión de liberación del NPI del médico #::

_____ Personal que ***liberar*** la transferencia NPI#/Firma/Función/Fecha del proveedor