NH Bureau of Developmental Services
DD/ABD/IHS Waiver Service Provider Acknowledgment

Service Provider Information:

Name: Email:

Address: Phone:

Service Provider Acknowledgment:

is an enrolled Medicaid Provider and agrees to provide the following services as outlined in 's Individual Service Agreement.

Waiver Type:

☐ Developmental Disabilities (DD) ☐ Acquired Brain Disorder (ABD) ☐ In-Home Supports (IHS)

Service(s)	Expected Start Date	Medicaid Provider #
Choose Service		
Choose Service		
Choose Service		
Choose Service		
Choose Service		
Choose Service		
Choose Service		

A copy of the current and/or proposed budget for the provision of each service, built on only those units the service will be provided as outlined in the service agreement, must be attached to this acknowledgment.

Is the budget attached? Yes ☐ No ☐

Any changes made to services listed above require an updated acknowledgment to be submitted

Provider Signature:	Date: