



PROGRAM AGREEMENT

Where it All Comes Together for a Better Future

I/We, _____, request care and training under the auspices of the MassHealth and/or the Department of Mental Retardation, which has contracted with Habilitation Assistance Corporation to provide services for my son/daughter, beneficiary/myself, from _____.

Member's Name: _____
Access Center: _____

To acknowledge my/our understanding and acceptance of the programs and services, I/we make the following agreement and consent to:

- 1. The provisions of the services outlined by the Department of Mental Retardation, MassHealth and Habilitation Assistance Corporation.
2. Participation in regularly scheduled meetings to review and/or amend the Individual Support Plan.
3. Authorization to arrange for emergency medical care to the nearest medical facility, provide routine medical and nursing care, monitor and maintain member's general health.
4. Permission for photograph to be taken and used solely for identification/communication purposes.
5. Authorization to transport and/or escort member to outside activities.
6. Permission to release information in situations necessitating assistance by local public service departments.
7. Permission to refer member for outside evaluations/therapy services as deemed necessary by interdisciplinary team.
8. Permission to allow review of member records by monitoring agencies and/or authorized Business Associates of Habilitation Assistance Corporation.

Signature of Member: _____

Signature of Legal Designee: _____

Print Name: _____

Please Check: [] Guardian [] Other: _____

Date of Completion: _____

THIS PROGRAM AGREEMENT WILL BE UPDATED ON AN ANNUAL BASIS.