DEPARTMENT OF HEALTH & HOSPITALS
Long Term-Personal Care Services Program

Agreement to Provide Services

Recipient Name: _____ **Date:** _____

Recipient Medicaid #: _____ **Provider #:** _____
(Your Agency's Provider Number)

Recipient SSN: _____ **Provider Name:** _____
(Your Company's Name)

A representative from our agency met with _____
(Recipient's Name)

on _____. We have reviewed his/her Plan of Care that has been approved by
(Date of Meeting with Recipient)

the Department of Health and Hospitals.

We agree to provide services to this recipient according to the:

- ☐ Initial Plan of Care dated _____.
- ☐ Reassessment Plan of Care dated _____.
- ☐ Status Change Plan of Care dated _____.

We understand that Affiliated Computer Systems (ACS) will not be able to issue an authorization to our agency until they receive this form signed by both the recipient or their personal representative and our agency representative.

_____ _____
Recipient Signature Date of Signature

_____ _____
Personal Representative Signature Date of Signature

_____ _____
Provider Agency Representative Signature Date of Signature

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Re-issued 06/01/08