

## SERVICE AGREEMENT FORM

**To be completed by all agencies licensed, funded and/or contracted with/by DHHS to provide services.**

The Provider \_\_\_\_\_, agrees to provide the following services:  
Contracting Agency

Relate services to ISP goal – include frequency and duration:

as defined in the ISP dated \_\_\_\_\_ to \_\_\_\_\_  
Consumer

This service is being offered in support of needs identified by the consumer as part of his/her Individualized Support Plan. Provision of these services is subject to the following requirements:

*\* Items 1, 2, & 3 apply only to consumers/clients who are members of the AMHI Consent Decree*

1. Prior written approval is received from a Consent Decree Coordinator before terminating or interrupting this service via use of the DHHS Termination/Interruption form.\*
2. Upon receiving written approval for interrupting or discontinuing the service, the provider will send 30 days written notice to the consumer including the right to grieve the decision. The community support worker and, if applicable, the guardian will also receive notification. \*
3. If it is determined that the consumer poses a threat of imminent harm to persons employed or served by the provider, then the provider will give notice which is reasonable under the circumstances.\*
4. If applicable, the provider will give other notice as required by law or regulation.
5. The provider will help the community service worker and consumer find alternate resources if appropriate.
6. The provider will assist DHHS with the collection of all necessary data.
7. Chart records will meet all applicable requirements of contracts, law, regulations and pertinent professional standards.
8. Should the consumer choose to discontinue the above service(s) and transfer to another provider before the end of the service agreement, the provider is responsible for helping the consumer transition. This will include providing copies of the current treatment plan (with the consumer's consent) to the new provider.

Signatures:

\_\_\_\_\_  
Consumer/Guardian/Date (Optional)

\_\_\_\_\_  
Provider Representative/Date

\_\_\_\_\_  
CSW/Date

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Agency

Date consumer or guardian provided with copy \_\_\_\_\_