

<b>PARTICIPANT NAME:</b>	<b>CIN (If applicable):</b>
<b>DESIGNATED PARTICIPANT REPRESENTATIVE NAME:</b>	
<b>CENTER NAME:</b>	<b>City</b>
<b>MANAGED CARE PLAN NAME (if applicable):</b>	

I understand that my participation at the ADHC / CBAS center is voluntary, and I may discontinue my participation at any time.

My personal plan is to attend the ADHC / CBAS center \_\_\_\_\_ days per week.

I participated in the center’s care planning process to determine the services I will receive at the ADHC / CBAS center and the center staff have explained my care plan to me. I understand that I may discuss my care plan with the center staff and may request revisions to my scheduled services at any time.

**Center staff:**

- Discussed with me the availability of community services and resources in addition to ADHC / CBAS
- May refer me to community services/resources as needed
- Provided me with a copy of my rights at the ADHC / CBAS center
- Discussed my rights with me, including my right to discuss my concerns about the care I receive at the center. If needed, I understand I can request help with resolving my concerns through the center’s grievance procedure
- Offered me a copy of my care plan that identifies the services I will receive at the center

- Will assess my needs on a recurring basis and I will participate in that process

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**Participant or Designated Participant Representative  
Signature**

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**Date**

I certify that I have explained this Participation Agreement and provided a copy to the participant/ or designated participant representative.

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**ADHC / CBAS Center Representative**

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**Title**

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**Date**