



TOP AID
HEALTHCARE, INC
CARE FOR HUMANITY

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Providers and Client Agreement for Services

Patient's Name _____ DOB _____

This agreement and the attached documents set forth the agreement between you, Top Aid Healthcare INC, and your (provider) _____ with respect to your participation in the Adult Foster Care Program (AFC) offered at your residence. Incorporated by reference are the Comprehensive Services Plan and Personal Care Plan describing the services that you, as the program participant, will receive from Top Aid Healthcare, Inc, your AFC provider.

By signing this agreement, you confirm that The Provider has reviewed the Comprehensive Care Plan with you and that your participation in the program is voluntary and that you agree to accept services outlined in the Care Plan on the schedule outline. You also understand that The Provider reserves the right to terminate services if the Program Director determines you are No longer eligible for service, or if your need for additional services exceeds The Provider capacity to deliver services to you.

In Addition, you understand that approval to participate in the Adult Foster Care (AFC) program is based upon you meeting criteria that included a review of your Physical needs related to activities of daily living and MassHealth approval of your eligibility to receive services. As such you understand that your continued to participate in the AFC program is dependent upon you continuing to meet those criteria.

Patient Signature _____ Date _____