TOP AID
HEALTHCARE, INC

TO REQUEST AN ADULT FAMILY CARE PROGRAM REVIEW, YOU MUST COMPLETE ANDRETURN THIS FORM WITHIN SEVEN CALADER DAYS FROM THE DATE OF YOUR EVALUATION, RE-EVALUATION, OR SERVICE AGREEMENT VISIT.

MAIL OR FAX THIS FORM TO: Top Aid Healthcare
69 Park Avenue
Worcester, MA 01605
Fax:508-519-0353

Please complete all appropriate sections:

1. Name:_____Telephone: _____
   Address: _____

2. I disagree with the decision made by TV,INC.regarding my:
   ☐ Evaluation ☐ Re-Evaluation ☐ AFC Service

I am requesting a review of this decision made by Top Aid Healthcare
Signature:_____ Telephone: _____

3. I would like(check one):
   _____A Telephone review at _____
   (Telephone Number)
   _____A review at Top Aid Healthcare

4. I would like to have the following person Represent me:
   Representative Name:_____
   Address:_____
   Telephone:_____

You will be notified in writing of the time, date, and location of the review meeting within 7 Calander days Top Aid Healthcare's receipt of this form. The Review meeting will be held within 7 calendar days of Top Aid Healthcare's receipt of this form.

For questions, please contact an AFC Supervisor or Program Director at 508-343-8555