Family Driven Support Services (FDSS) Letter of Agreement For Consumer Secured Service Between

Agency Name:

Northeast Community Center for Mental
Health/Mental Retardation ____________________
And ____________________
Roosevelt Blvd. & Adams Ave. ____________________
Philadelphia, PA 19124 ____________________

1. I ________________________________ have participated in the development of my Family Plan, covering the period of July 1, 2001 through June 30, 2002 and agree to its terms.

2. I understand that it is my responsibility to locate, choose and instruct a caregiver/ vendor who will provide me with the services called for by my Family Plan. I understand that the caregiver/vendor will be my employee and not the employee or agent of Northeast Community Center for Mental Health/Mental Retardation. I understand that Northeast Community Center for Mental Health/Mental Retardation is not in any way responsible for the quality of performance of the caregiver/vendor I select.

3. I understand that FDSS will reimburse me for services I purchased under the following conditions:

a. When I am accepted for service under the FDSS Program, my Family Plan will specify the type and amount of service I can contract for under this program. FDSS Program will pay only for the types and amounts of services listed in my Family Plan and only for the period of time covered by the Plan.

b. When I am accepted for service under the FDSS Program, I will submit my requests for reimbursement after the service was purchased with an invoice receipt to Northeast Community Center for Mental Health/Mental Retardation. Each invoice/receipt must be signed by the provider and me and will include the dates of service, if applicable.

4. It will take no more than thirty (30) days from the time Northeast Community Center for Mental Health/Mental Retardation receives my invoice/receipt to the time the check is mailed to me.

5. Northeast Community Center for Mental Health/Mental Retardation will reimburse the provider directly if Northeast Community Center for Mental Health/Mental Retardation authorized and arranged for the service.

6. If at any time my Family Plan does not meet my needs, it will be my responsibility to contact the FDSS Program to arrange for changes in the Plan. FDSS will not pay for new or different services unless Plan changes providing for those services have been approved before the services are performed.

7. This Agreement may be terminated at any time by me.

8. Northeast Community Center for Mental Health/Mental Retardation can only terminate this Agreement if at any time in their professional judgment there is evidence of non-compliance with the above stipulation, or if in their professional judgment, the Agreement is no longer in the best interest of the client being served. If I do not agree with Northeast Community Center for Mental Health/Mental Retardation's decision to terminate, I can appeal according to Northeast Community Center for Mental Health/Mental Retardation's grievance procedures.

9. All of the above Agreements are contingent on availability of funds to the FDSS Program.

I have read and understand this Agreement.

Family Member ________________________________ Date ____________________

FDSS Coordinator ______________________________ Date ____________________