

VOLUNTARY FINANCIAL SUPPORT AGREEMENT

Person's Name	Person's Street Address
Guardian's Name (if applicable)	Person's City, State and Zip Code

I, the above mentioned person, voluntarily request financial support from the Department of Human Services, Division of Services for People with Disabilities or a provider under contract with the Division. I have discussed possible benefits, disruptions, intrusions, alternatives to service, and requirements for continued services, and agree to the conditions thereof. I have been made aware of my rights and responsibilities in receiving financial supports, and the Department of Human Services or provider agency authority and responsibilities in providing the requested services.

The financial support I will receive will involve management of income and resources from ___all sources ___SSI ___SSA ___employment ___other (please specify)

This agreement will become effective: this _____ day of _____, 200__, and will continue until: (choose a or b)
a. the _____ day of _____, 200__, or
b. until services are no longer deemed necessary by myself and/or the Department of Human Services.

I understand that this is not a legally binding document, and that the sole purpose is to identify the voluntary arrangement of services.

Person's Signature _____ Date _____

Guardian's Signature _____ Date _____

Division/Provider Staff Signature _____ Date _____