Commonwealth of Massachusetts
Executive Office of Health and Human Services
Executive Office of Elder Affairs

Voluntary Assent Waiver

Client:

_____

_____

_____

Aging Services Access Point (ASAP):

Central Boston Elder Services, Inc.

2315 Washington Street

Boston, MA 02119

I understand that my _____ will be:
(type of home care service)

☐ **reduced/changed** from _____

to _____ on _____ (date).

☐ **terminated** on _____ (date).

I will no longer receive home care services and I will no longer participate in the waiver program.

I know that I have the right to appeal decisions made by the ASAP. I agree with the decision stated above and I do not want to appeal this decision.

Signatures:

Client: _____ Date: _____

Case Manager: _____ Date: _____