



SERVICE AGREEMENT

(For use by individuals who are not affiliated with an agency)

Beneficiary Name: _____

Individual Requesting Service: _____

Need for Service: _____

Location of Service: _____

Description of Service: _____

Service Provider Information:

Name of Provider: _____

Mailing Address: _____
(Street) (City, State) (Zip Code)

Phone Numbers: _____
(Home) (Cell) (Other, please specify)

Email Address(es): _____

Scheduled Hours per Week (up to 10): _____ Rate per Hour: \$ _____

****PLAN of Massachusetts and Rhode Island, as Trustee, has total and sole discretion in making any payment from an individual's Special Needs Pooled Trust account. Neither the Trust Beneficiary nor any person acting on behalf of the Trust Beneficiary can require payments from an individual's account.**

*****If the service being described under this agreement is for guardian or conservatorship purposes, you are certifying that you are not being paid by a state agency or other source for providing this service.**

I hereby attest, under the pains and penalties of perjury, that the above services are for the sole benefit of the Trust Beneficiary named on this form.

Signature of Provider

Date

Submit to:

PLAN of Massachusetts and Rhode Island
1340 Centre Street, Suite 102
Newton Centre, Massachusetts 02459
Phone: (617) 244-5552 Fax: (617) 795-0589
E-mail: info@planofma-ri.org

PLAN Office Use:

Date Received: _____ via: Mail Fax SC

Service Coordinator Authorization: _____ Date: _____