Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

**Full Service Partnership Agreement**

|  |  |
| --- | --- |
| Start Date: |  |
| End Date: |  |

I have discussed the Mental Health Services Act (MHSA) Full Service Partnership (FSP) Program with my Personal Service Coordinator (PSC) and agree to participate in the program. I understand this is a voluntary program based upon a partnership between myself and the FSP staff. I agree to work on achieving recovery through my recovery goals with my Personal Service Coordinator. I also understand that I can elect to withdraw from the FSP program at any time.

Staff: Date:

Signature: Date:

Printed Name: