STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
ADHC/CBAS PARTICIPATION AGREEMENT CDA 7000 (REV 2/2024)

Participant Name:	**CIN (if applicable):**
Participant's Authorized Representative Name:	
Center Name:	**City:**
Managed Care Plan Name (if applicable):	

I have chosen to participate in the ADHC / CBAS program and plan to attend the ADHC / CBAS center ____ days per week.

I participated in the center's care planning process to identify my needs and preferences to determine the services I will receive at the ADHC / CBAS center. The center staff have explained my care plan to me. I understand that I may discuss my care plan with the center staff and may request revisions to my scheduled services at any time.

I understand that my participation at the ADHC / CBAS center is voluntary, and I may discontinue my participation at any time.

Center staff:

- Discussed with me the availability of community services and resources in addition to ADHC / CBAS
- May refer me to community services/resources as needed
- Provided me with a copy of my rights at the ADHC / CBAS center
- Discussed my rights with me, including my right to discuss my concerns about the care I receive at the center. If needed, I understand I can request help with resolving my concerns through the center's grievance procedure
- Offered me a copy of my care plan that identifies the services I will receive at the center
- Will assess my needs on a recurring basis and I will participate in that process

Participant or Participant's Authorized Representative Signature _____ **Date** _____

I certify that I have explained this Participation Agreement and provided a copy to the participant/ or participant's authorized representative.

ADHC/CBAS Center Representative _____ **Title** _____ **Date** _____