



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

## Voluntary Assent Waiver

Client:

Aging Services Access Point (ASAP):

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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: \_\_\_\_\_