Family Support Agreement for Health Care Needs

Date: [Insert Date]

Parties Involved:

- Provider: [Provider's Name]
- Family Member: [Family Member's Name]
- Guardian (if applicable): [Guardian's Name]

Purpose

This agreement outlines the roles and responsibilities of all parties involved in providing support for [Family Member's Name]'s health care needs.

Health Care Needs

[Describe the specific health care needs of the family member, including any medical conditions, required treatments, and support services.]

Responsibilities

Provider Responsibilities

- [Provider will perform regular check-ups and maintain communication with the family.]
- [Provider will ensure access to necessary medications and treatments.]

Family Responsibilities

- [Family will ensure medication is taken as prescribed.]
- [Family will communicate any changes in health status to the provider immediately.]

Duration of Agreement

This agreement will remain in effect from [Start Date] to [End Date], unless terminated by mutual consent.

Signatures

By signing below, the parties agree to the terms outlined in this Family Support Agreement.

_____
[Provider's Name]
[Date]

_____
[Family Member's Name]
[Date]

_____
[Guardian's Name, if applicable]
[Date]