SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Full Service Partnership Agreement

I agree to participate in a Full Service Partnership program. As a Full Service Partner, I will work with staff from the _____ program to help develop my individualized care plan. As part of this program, I agree to provide information to complete the required information for the plan and ongoing data requests. This will be a collaborative relationship to enable me to work with staff to accomplish my goals for recovery. Some of the areas I would like to work on include:

_____ **Mental Health Issues**

_____ **Housing**

_____ **Family Issues**

_____ **Employment**

_____ **Education**

_____ **Healthcare**

_____ **Legal issues**

_____ **Substance use**

_____ **Community connections / social networks**

_____ **Other**

Name of Full Service Partner: _____

Signature of Partner: _____ **Date:** _____

Signature of parent/legal guardian: _____ **Date:** _____/_____/20_____

Name of the FSP point person/TBC members: _____

_____

***The items on this form were discussed with the FSP consumer on _____/_____/20___, and are being addressed. At this time the FSP consumer has chosen not to sign this form.**