



**BEACON HEALTH STRATEGIES
FAMILY STABILIZATION SERVICES
CONSENT FORM**

I, _____, give my consent for _____,
(Member/Guardian) (Member)

and our family to receive Family Stabilization Team (FST) Services.

I also consent to having our service providers and state agency representatives contacted regarding their involvement with my family's treatment.

Name/Agency/Phone #

Name/Agency/Phone #

Name/Agency/Phone #

Name/Agency/Phone #

I also acknowledge that Family Stabilization Team (FST) services have been explained to me and I understand them.

NHP Member Signature

Parent/Guardian Signature

Date