Volunteer Health Services Program Disclosure Form and Eligibility Information

Please initial each statement to indicate you or your legal representative have read and understand the "Volunteer Health Services Program Disclosure" form as detailed below.

___ **I understand the healthcare provider treating me is considered a public employee of the State under the Wyoming Governmental Claims Act.**

___ **I understand the medical facility at which I am receiving treatment is considered a State facility under the Wyoming Governmental Claims Act.**

___ **I understand the healthcare provider's liability and facility's liability is limited by the provisions of the Wyoming Governmental Claims Act when providing volunteer health services.**

___ **I understand if any injury or damage suffered as the result of any negligence of the healthcare provider or medical facility occurs while I receive volunteer health services, any claim I bring is subject to the procedures and limits of the Wyoming Governmental Claims Act.**

___ **I understand I may decline treatment from healthcare providers.**

___ **I am not covered under a health insurance or healthcare policy, contract or plan, or I am covered under a health insurance or healthcare policy, contract or plan but was denied coverage by the policy, contract or plan.**

___ **I qualify as a low-income person according to the following monthly income limits for the Volunteer Health Services Program.**

Number of persons in household	1	2	3	4	5	6	7	8	9	10	11	12
200 % FPL	$2,024	$2,744	$3,464	$4,184	$4,904	$5,624	$6,344	$7,064	$7,784	$8,504	$9,224	$9,944

Patient Name Printed

Legal Representative Name Printed

Patient Signature Date

Legal Representative Signature Date

Parent or Guardian Name if Patient is a Minor

Parent or Guardian Signature Date