Aging Division

Emergency Rental Assistance Program – Housing Stability Services (ERAP-HSS)

CLIENT SERVICE PLAN

Client Name: ____

ERAP Applicant ID: ____

Physical Address: ____

City: ________________________________ State: ____________ Zip: ___________________

Mailing Address (if different than Physical Address): _____________________________________

City: ________________________________ State: ____________ Zip: ___________________

Phone Number: _________________________

Emergency Contact: ___________________________ Phone Number: _______________________

This service plan **MUST** be completed 90 days after the initial start date then every 90 days thereafter. If **no** change in status, indicate 90th day, end date and initial in the spaces indicated. CC stands for Care Coordinator Officiant.

Start Date________End Date___________CC's Initials______________Client's Initials ______________
1) 90th Day_________End Date___________CC's Initials______________Client's Initials ______________
2) 90th Day_________End Date___________CC's Initials______________Client's Initials ______________
3) 90th Day_________End Date___________CC's Initials______________Client's Initials ______________
4) 90th Day_________End Date___________CC's Initials______________Client's Initials ______________
5) 90th Day_________End Date___________CC's Initials______________Client's Initials ______________

Outcome(s)

(Please check ALL outcomes that are applicable)

____ 1) To maintain client independence by preventing inappropriate or premature institutionalization

____ 2) To repair the home to allow the client to either age in place or live independently with their disability

____ 3) To develop social interactions with the use of computer hardware for video and written communication

____ 4) To decrease negative aspects of poor mental health that can lead to hoarding and cleaning after hoarding

____ 5) Other:____

____ ____
Care Coordinator Name (Printed) Subrecipient's Business Name

I agree with the above plan of services; will participate in my services; and understand my consumer rights and responsibilities (see back of page). I will notify my Care Coordinator of any changes, needs, problems, or issues related to the provision of my services.

____ ____
Client Signature Date Care Coordinator Signatures Date

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ERAP-HSS Services		
Service Category	**Sub-Service**	**Agreed Upon**
Home Modifications	n/a	
Trailer/Mobile Home Repairs	n/a	
Homemaking Services	Homemaking Services - Homemaking, Chores, Cleaning	
Personal Care – Skilled Nursing Services	Registered Nurse (RN)	
	Licensed Practical Nurse (LPN)	
	Personal Care – CNA – Certified Nursing Assistant (CNA)	
Non-Medical Transportation	Non-Medical Transportation - *Wheelchair & Non-Wheelchair Accessible Vehicle*	
Personal Emergency Response Systems (PERS)	PERS - Landline Installation	
	PERS - Landline Monitoring	
	PERS - Cellular Installation	
	PERS - Cellular Monitoring	
Information Technology Hardware	n/a	
Independent Living Skills	Life Coaching	
	Money Management	
Hoarding Services	Cleaning	
	Mental Health Counseling	

Extra Information for Specialized Services			
Service Category	**Sub-Service**	**Minimum Forms Needed (Extras can be attached to Intake Form or Service Plan at subrecipient's discretion)**	**Frequency**
Home Modifications	n/a	__ Client Intake Form __ Initial Evaluation & Project Planning __ Client Service Plan __ Letter from Landlord __ Final Evaluation	Once in Grant Period or Change of Status
Trailer/Mobile Home Repairs	n/a	__ Client Intake Form __ Initial Evaluation & Project Planning __ Client Service Plan __ Final Evaluation	Once in Grant Period or Change of Status
Personal Care – Skilled Nursing Services	Registered Nurse (RN) Licensed Practical Nurse (LPN) Certified Nursing Assistant (CNA)	__ Nursing Assessment Form (Not provided by AGD) Date:____________________ __ Nursing Delegation Form (Not provided by AGD) Date:____________________	Once in Grant Period or Change of Status
Hoarding Services	Cleaning	__ Client Intake Form __ Initial Evaluation & Project Planning __ Client Service Plan __ Final Evaluation	Once in Grant Period or Change of Status
All Other Services		__ Client Intake Form __ Client Service Plan	Once in Grant Period or Change of Status

Description of Services & Information:

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Client Rights

- The Client has the right to be informed, in advance, about the services to be provided, and of any changes to the services to be provided.
- The client has the right to participate in the planning of the services and changes to the services.
- The client has the right to refuse services, and to be informed of the consequences of their decision.
- The client has the right to be fully informed of the agency's policies for the services, prior to receiving services.
- The client has the right to be treated with respect and dignity.
- The client has the right to have their property treated with respect.
- The client has the right to expect their personal information and records to be maintained with confidentiality.
- The client has the right to voice their grievance regarding services that are provided or fail to be provided, or regarding the lack of respect for property by anyone who is providing services, without fear of termination or retaliation.
- The client has the right to be advised of the availability of the Aging Division, Community Living Section's toll-free number 1-800-442-2766.
- The client shall be given the written notice of their rights prior to the start of services.
- The client has the right to call the Department of Family Services at 1-800-457-3659

Client Responsibilities

- The client has the responsibility to keep provides aware of any change in their living situation.
- The client has the responsibility to provide accurate information to the Care Coordinator when they visit.
- The client has the responsibility to be cooperative, actively participate in the development of, and follow their service plan.
- The client has the responsibility to keep appointments, or notify the provider when they are unable to keep appointments.
- The client has the responsibility to ask questions if the program services are unclear.
- Wyoming is a mandatory reporting state regarding elder abuse. Call your local Department of Family Services or law enforcement.