ERAP-HSS Client Intake & Evaluation Form

This form may not be altered. Created 07/19/2021. Updated 11/19/2021 - Version 2

Basic Client Information	**Date of Assessment:** / /	***ERAP Applicant ID:***	
Legal First Name:	Legal Last Name:	Middle Initial:	Preferred Name:
Date of Birth: / /	Age:	Gender Identity: ❒ Male/Man ❒ Female/Woman ❒ Transgender ❒ Other: _____	Biological Sex at Birth: ❒ Male ❒ Female ❒ Intersex ❒ Other: _____

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Other: _____	Race: ❒ White (Caucasian) ❒ American Indian/Alaskan ❒ Asian/Asian American ❒ Black/African American ❒ Other: _____ ❒ Native Hawaiian/Pacific Islander
Residential Address:	❒ *Check if same as Residential Address* Mailing Address:
Residential City, State and Zip Code:	Mailing City, State and Zip Code:
County of Residence:	Email:
Primary Phone Number: ( )	Secondary Phone Number: ( )

Are you disabled? ❒ Yes ❒ No	Primary Language: ❒ English ❒ Spanish ❒ Other: _____	Are you a senior citizen? ❒ Yes ❒ No
Are you a veteran? ❒ Yes ❒ No	Do you live alone? ❒ Yes ❒ No	Do you live in a rural area? ❒ Yes ❒ No

Is your monthly income at or below this amount (Depending on your family size)? ❒ Yes ❒ No

Family size 1 - $1,073 ***Family size 2 - $1,452*** ***Family size 3 - $1,830*** ***Family size 4 - $2,208***

Emergency contact name:	*Relationship:*	*Phone number:* ( )

Declaration: I hereby certify that all of the information provided in this questionnaire is true and correct to the best of my knowledge and belief. A signature will be considered acceptance that this form and the information contained therein is true and accurate.

Use of Information: The information you provide on the ERAP-HSS Client Intake Form will be disclosed to the Wyoming Department of Health (WDH), Aging Division, Community Living Section. The WDH will only use or disclose the information as permitted by the Health Insurance Portability and Accountability Act (HIPAA). For more detailed information on how the WDH may use or disclose your health information, please see the WDH Notice of Privacy Practices found online at https://health.wyo.gov/admin/privacy/ or you may request a copy from the WDH Aging Division by calling 1 (800) 442-2766. If you feel you have been treated inappropriately, received services that have not been of the quality expected, or you have not been provided services as stated in the service plan, contact the Department of Family Services at (800)-457-3659 or the WDH Aging Division, Community Living Section at (800) 442-2766.

Client Signature: _____ **Date:** _____

*This page is for ERAP-HSS, all clients receiving one or more services under the ERAP-HSS program.

Intake Assessment/Renewal of a Client's Ability to Perform Activities of Daily Living (All Participants)

Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
	Rate client's ability to perform BATHING.		**Rate client's ability to PREPARE MEALS.**
0	Independent	**0**	Independent/ prepares simple or partial meals
2	Intermittent supervision/ minimal assistance	**1**	Prepares with verbal cueing or reminding
4	Partial assistance	**2**	Prepares with minimal help
6	Total dependence	**3**	Does not prepare any meals
	Rate client's ability to EAT.		**Rate client's ability to perform SHOPPING.**
0	Independent	**0**	Independent
2	Intermittent supervision/ minimal assistance	**2**	Does with supervision/reminding
4	Extensive help	**4**	Shops with hands-on help/ assistive devices
6	Total dependence	**6**	Done by others or shops by phone
	Rate client's Bowel/Bladder CONTINENCE.		**Rate client's ability to MANAGE MEDICATIONS.**
0	Independent	**0**	Independent/ does not occur
1	Requires assistance sometimes	**2**	Done with help some of the time
2	Totally dependent	**4**	Done with help all of the time
	Rate client's ability to perform TRANSFER.		**Rate client's ability to MANAGE MONEY.**
0	Independent	**0**	Completely independent
1	Limited physical assistance	**2**	Needs assistance sometimes
2	Extensive assistance	**4**	Needs assistance most of the time
3	Total dependence	**6**	Completely dependent
	Rate client's ability to perform TOILETING.		**Rate the client's ability to perform LIGHT HOUSEWORK.**
0	Independent	**0**	Independent
2	Reminding, cueing or monitoring	**1**	Needs assistance sometimes
4	Limited physical assistance	**2**	Needs assistance most of the time
6	Extensive assistance	**3**	Unable to perform tasks
8	Total dependence		
	Rate client's ability to perform DRESSING.		**Rate the client's ability to perform LAUNDRY.**
0	Independent	**0**	No setup or physical help/ Independent
1	Limited physical assistance	**1**	Supervision/cueing required
2	Reminding, cueing or monitoring	**2**	Totally dependent
3	Extensive assistance		
4	Total dependence		
Provider Signature: _____			**Rate client's ability to USE THE TELEPHONE.**
Date: _____		**0**	Independent
Quarter 1 of 4: _____		**1**	Can perform with some help
ADL Count of Categories >0: _____		**2**	Cannot perform function at all without help
ADL Total Score: _____			**Rate the client's ability to access TRANSPORTATION.**
IADL Count of Categories >0: _____		**0**	Independent
IADL Total Score: _____		**1**	Done with help some of the time
Client Signature & Initials: _____		**2**	Done by others
		3	Requires ambulance

*This page is for ERAP-HSS, all clients receiving one or more services under the ERAP-HSS program

**Each intake form should end up with 4 quarterly assessments ADL's and IADL's a year unless. An initial intake is the first quarter assessment.

Home Modifications, Repairs & Hoarding - Initial Evaluation & Project Planning	YES	NO	IF NO, THE PLAN OF ACTION IS:
General Home Access: Does the client have safe access to all necessary areas of their home? • Is the client's home free of clutter? • Is the home safe for someone with Alzheimer's disease, dementia or other cognitive impairments? •			
Entryways, Steps, Ramps and Hallways: Are the steps and walkways outside the client's home in good condition? • Are transitions easy between sections inside the home? • Are ramps sturdy and effective? • Are hallways wide enough? •			
Adequate Lighting: Are all areas of the house, outside living space and the garage serviced with adequate light? • Are switches easy to reach? •			
Doors: Are doors wide enough for wheelchair access? • Are handles, levers and latches easy to use? • Is the client able to unlock doors and/or windows? •			
Environment: Is the client's home free of insects/rodents? • Is the client's home free from odors? • Is the home temperate? • Is the client's home electrical hazard free? •			
Kitchen & Laundry: Do appliances work properly? • Are they easy to use? • Is there adequate/proper food storage and waste removal? • Can all cupboards, counters and appliances be safely reached? • Is the flooring adequate for their needs? •			
Bathroom: Is the bathroom adequate to meet the client's needs? • Can all cupboards, counters and utilities be safely reached? • Can the client shower/bath safely? • Are sinks wheelchair accessible? • Is there a non-skid bath mat in the bathtub? •			
Emergency Exits: In the case of an emergency, would the client be able to get out of his/her home safely on their own? • Are smoke and carbon monoxide detectors present and in working order? • Is the client's home free from fire hazards (i.e. frayed cords, items next to heater, etc.)? •			
Stairs: Do stairs have sturdy rails on both sides that are securely fastened? • Are the stair treads sturdy, not deteriorating or broken? • Are top and bottom steps highlighted? • Are stairs and landings well lit, light switches top and bottom? •			
All Rooms: Are beds and couches easy to get in/out of? • Are closets easy to enter, use, with items spaced correctly? • Are cords and wires safely hidden away? •			
General Home Condition: Is the home sturdy, weather proofed and insulated for heat and have adequate cooling? • Are windows easy to use and accessible? • Is A/C medically necessary for this person? • Is the roof in good condition? •			

Project Planning & Other Notes:

Client Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

(Circle the correct program below)

• HM • T/MHR • HS

*This page is only for those ERAP-HSS clients receiving: Home Modifications, Trailer/Mobile Home Repairs or Hoarding Services - Cleaning

Home Modifications, Repairs & Hoarding - Final Evaluation	**YES**	**NO**	**IF NO, PLAN OF ACTION IS:**
General Home Access: Does the client have safe access to all necessary areas of their home? • Is the client's home free of clutter? • Is the home safe for someone with Alzheimer's disease, dementia or other cognitive impairments? •			
Entryways, Steps, Ramps and Hallways: Are the steps and walkways outside the client's home in good condition? • Are transitions easy between sections inside the home? • Are ramps sturdy and effective? • Are hallways wide enough? •			
Adequate Lighting: Are all areas of the house, outside living space and the garage serviced with adequate light? • Are switches easy to reach? •			
Doors: Are doors wide enough for wheelchair access? • Are handles, levers and latches easy to use? • Is the client able to unlock doors and/or windows? •			
Environment: Is the client's home free of insects/rodents? • Is the client's home free from odors? • Is the home temperate? • Is the client's home electrical hazard free? •			
Kitchen & Laundry: Do appliances work properly? • Are they easy to use? • Is there adequate/proper food storage and waste removal? • Can all cupboards, counters and appliances be safely reached? • Is the flooring adequate for their needs? •			
Bathroom: Is the bathroom adequate to meet the client's needs? • Can all cupboards, counters and utilities be safely reached? • Can the client shower/bath safely? • Are sinks wheelchair accessible? • Is there a non-skid bath mat in the bathtub? •			
Emergency Exits: In the case of an emergency, would the client be able to get out of his/her home safely on their own? • Are smoke and carbon monoxide detectors present and in working order? • Is the client's home free from fire hazards (i.e. frayed cords, items next to heater, etc.)? •			
Stairs: Do stairs have sturdy rails on both sides that are securely fastened? • Are the stair treads sturdy, not deteriorating or broken? • Are top and bottom steps highlighted? • Are stairs and landings well lit, light switches top and bottom? •			
All Rooms: Are beds and couches easy to get in/out of? • Are closets easy to enter, use, with items spaced correctly? • Are cords and wires safely hidden away? •			
General Home Condition: Is the home sturdy, weather proofed and insulated for heat and have adequate cooling? • Are windows easy to use and accessible? • Is A/C medically necessary for this person? • Is the roof in good condition? •			
Project Planning & Other Notes:			

Client Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

(Circle the correct program below)

• HM • T/MHR • HS

*This page is only for those ERAP-HSS clients receiving: Home Modifications, Trailer/Mobile Home Repairs or Hoarding Services - Cleaning

90th Day Client Quarterly Assessment – Quarter 2 of 4

Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
	Rate client's ability to perform BATHING.		**Rate client's ability to PREPARE MEALS.**
0	Independent	**0**	Independent/ prepares simple or partial meals
2	Intermittent supervision/ minimal assistance	**1**	Prepares with verbal cueing or reminding
4	Partial assistance	**2**	Prepares with minimal help
6	Total dependence	**3**	Does not prepare any meals
	Rate client's ability to EAT.		**Rate client's ability to perform SHOPPING.**
0	Independent	**0**	Independent
2	Intermittent supervision/ minimal assistance	**2**	Does with supervision/reminding
4	Extensive help	**4**	Shops with hands-on help/ assistive devices
6	Total dependence	**6**	Done by others or shops by phone
	Rate client's Bowel/Bladder CONTINENCE.		**Rate client's ability to MANAGE MEDICATIONS.**
0	Independent	**0**	Independent/ does not occur
1	Requires assistance sometimes	**2**	Done with help some of the time
2	Totally dependent	**4**	Done with help all of the time
	Rate client's ability to perform TRANSFER.		**Rate client's ability to MANAGE MONEY.**
0	Independent	**0**	Completely independent
1	Limited physical assistance	**2**	Needs assistance sometimes
2	Extensive assistance	**4**	Needs assistance most of the time
3	Total dependence	**6**	Completely dependent
	Rate client's ability to perform TOILETING.		**Rate the client's ability to perform LIGHT HOUSEWORK.**
0	Independent	**0**	Independent
2	Reminding, cueing or monitoring	**1**	Needs assistance sometimes
4	Limited physical assistance	**2**	Needs assistance most of the time
6	Extensive assistance	**3**	Unable to perform tasks
8	Total dependence		
	Rate client's ability to perform DRESSING.		**Rate the client's ability to perform LAUNDRY.**
0	Independent	**0**	No setup or physical help/ Independent Supervision/cueing
1	Limited physical assistance	**1**	required
2	Reminding, cueing or monitoring	**2**	Totally dependent
3	Extensive assistance		
4	Total dependence		
Provider Signature: _____			**Rate client's ability to USE THE TELEPHONE.**
Date: _____		**0**	Independent
ADL Count of Categories >0: _____		**1**	Can perform with some help
ADL Total Score: _____		**2**	Cannot perform function at all without help
IADL Count of Categories >0: _____			**Rate the client's ability to access TRANSPORTATION.**
IADL Total Score: _____		**0**	Independent
Client Signature & Initials: _____		**1**	Done with help some of the time
		2	Done by others
		3	Requires ambulance

*This page is for those ERAP-HSS clients receiving: Homemaking Services, Personal Care – Skilled Nursing Services, Non-Medical Transportation, Personal Emergency Response System (PERS), Information Technology Hardware - Quarterly (optional), Independent Living Skills or Hoarding Services – Mental Health Counseling

**Each intake form should end up with 4 quarterly assessments ADL's and IADL's a year unless. An initial intake is the first quarter assessment.

90th Day Client Quarterly Assessment – Quarter 3 of 4

Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
	Rate client's ability to perform BATHING.		**Rate client's ability to PREPARE MEALS.**
0	Independent	**0**	Independent/ prepares simple or partial meals
2	Intermittent supervision/ minimal assistance	**1**	Prepares with verbal cueing or reminding
4	Partial assistance	**2**	Prepares with minimal help
6	Total dependence	**3**	Does not prepare any meals
	Rate client's ability to EAT.		**Rate client's ability to perform SHOPPING.**
0	Independent	**0**	Independent
2	Intermittent supervision/ minimal assistance	**2**	Does with supervision/reminding
4	Extensive help	**4**	Shops with hands-on help/ assistive devices
6	Total dependence	**6**	Done by others or shops by phone
	Rate client's Bowel/Bladder CONTINENCE.		**Rate client's ability to MANAGE MEDICATIONS.**
0	Independent	**0**	Independent/ does not occur
1	Requires assistance sometimes	**2**	Done with help some of the time
2	Totally dependent	**4**	Done with help all of the time
	Rate client's ability to perform TRANSFER.		**Rate client's ability to MANAGE MONEY.**
0	Independent	**0**	Completely independent
1	Limited physical assistance	**2**	Needs assistance sometimes
2	Extensive assistance	**4**	Needs assistance most of the time
3	Total dependence	**6**	Completely dependent
	Rate client's ability to perform TOILETING.		**Rate the client's ability to perform LIGHT HOUSEWORK.**
0	Independent	**0**	Independent
2	Reminding, cueing or monitoring	**1**	Needs assistance sometimes
4	Limited physical assistance	**2**	Needs assistance most of the time
6	Extensive assistance	**3**	Unable to perform tasks
8	Total dependence		
	Rate client's ability to perform DRESSING.		**Rate the client's ability to perform LAUNDRY.**
0	Independent	**0**	No setup or physical help/ Independent Supervision/cueing
1	Limited physical assistance	**1**	required
2	Reminding, cueing or monitoring	**2**	Totally dependent
3	Extensive assistance		
4	Total dependence		
Provider Signature: _____			**Rate client's ability to USE THE TELEPHONE.**
Date: _____		**0**	Independent
ADL Count of Categories >0: _____		**1**	Can perform with some help
ADL Total Score: _____		**2**	Cannot perform function at all without help
IADL Count of Categories >0: _____			**Rate the client's ability to access TRANSPORTATION.**
IADL Total Score: _____		**0**	Independent
Client Signature & Initials: _____		**1**	Done with help some of the time
		2	Done by others
		3	Requires ambulance

*This page is for those ERAP-HSS clients receiving: Homemaking Services, Personal Care – Skilled Nursing Services, Non-Medical Transportation, Personal Emergency Response System (PERS), Information Technology Hardware - Quarterly (optional), Independent Living Skills or Hoarding Services – Mental Health Counseling

**Each intake form should end up with 4 quarterly assessments ADL's and IADL's a year unless. An initial intake is the first quarter assessment.

90th Day Client Quarterly Assessment – Quarter 4 of 4

Score	ADLs (Activities of Daily Living)	Score	IADLs (Instrumental Activities of Daily Living)
	Rate client's ability to perform BATHING.		**Rate client's ability to PREPARE MEALS.**
0	Independent	**0**	Independent/ prepares simple or partial meals
2	Intermittent supervision/ minimal assistance	**1**	Prepares with verbal cueing or reminding
4	Partial assistance	**2**	Prepares with minimal help
6	Total dependence	**3**	Does not prepare any meals
	Rate client's ability to EAT.		**Rate client's ability to perform SHOPPING.**
0	Independent	**0**	Independent
2	Intermittent supervision/ minimal assistance	**2**	Does with supervision/reminding
4	Extensive help	**4**	Shops with hands-on help/ assistive devices
6	Total dependence	**6**	Done by others or shops by phone
	Rate client's Bowel/Bladder CONTINENCE.		**Rate client's ability to MANAGE MEDICATIONS.**
0	Independent	**0**	Independent/ does not occur
1	Requires assistance sometimes	**2**	Done with help some of the time
2	Totally dependent	**4**	Done with help all of the time
	Rate client's ability to perform TRANSFER.		**Rate client's ability to MANAGE MONEY.**
0	Independent	**0**	Completely independent
1	Limited physical assistance	**2**	Needs assistance sometimes
2	Extensive assistance	**4**	Needs assistance most of the time
3	Total dependence	**6**	Completely dependent
	Rate client's ability to perform TOILETING.		**Rate the client's ability to perform LIGHT HOUSEWORK.**
0	Independent	**0**	Independent
2	Reminding, cueing or monitoring	**1**	Needs assistance sometimes
4	Limited physical assistance	**2**	Needs assistance most of the time
6	Extensive assistance	**3**	Unable to perform tasks
8	Total dependence		
	Rate client's ability to perform DRESSING.		**Rate the client's ability to perform LAUNDRY.**
0	Independent	**0**	No setup or physical help/ Independent Supervision/cueing
1	Limited physical assistance	**1**	required
2	Reminding, cueing or monitoring	**2**	Totally dependent
3	Extensive assistance		
4	Total dependence		
Provider Signature: _____			**Rate client's ability to USE THE TELEPHONE.**
Date: _____		**0**	Independent
ADL Count of Categories >0: _____		**1**	Can perform with some help
ADL Total Score: _____		**2**	Cannot perform function at all without help
IADL Count of Categories >0: _____			**Rate the client's ability to access TRANSPORTATION.**
IADL Total Score: _____		**0**	Independent
Client Signature & Initials: _____		**1**	Done with help some of the time
		2	Done by others
		3	Requires ambulance

*This page is for those ERAP-HSS clients receiving: Homemaking Services, Personal Care – Skilled Nursing Services, Non-Medical Transportation, Personal Emergency Response System (PERS), Information Technology Hardware - Quarterly (optional), Independent Living Skills or Hoarding Services – Mental Health Counseling

**Each intake form should end up with 4 quarterly assessments ADL's and IADL's a year unless. An initial intake is the first quarter assessment.

Wyoming Department of Health

Aging Division

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

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 at initial intake/start for all services, then every 90 days thereafter for all non-project services (Information Technology Hardware is optional for client and sub-recipient's, service plan is only needed if quarterly checks are requested). If **no** change in status, indicate 90th day, the end date and initial in the spaces indicated. ***Please indicate the start point of assessment and the end point of the assessment.*** ***Forms are located at the end of the Intake Form.***

Start Date_____ End Date_____ Sub-recipient's Initials_____ Client's Initials _____
1) 90th Day_____ End Date_____ Sub-recipient's Initials_____ Client's Initials _____
2) 90th Day_____ End Date_____ Sub-recipient's Initials_____ Client's Initials _____
3) 90th Day_____ End Date_____ Sub-recipient's Initials_____ Client's Initials _____
4) 90th Day_____ End Date_____ Sub-recipient's Initials_____ Client's Initials _____
5) 90th Day_____ End Date_____ Sub-recipient'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:_____

_____ _____
Sub-recipient's Name – Officiant (Printed) Sub-recipient's Business Name

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

_____ _____
Client Signature Date Sub-recipient's Signature Date

Original: Stays with sub-recipient	Copy: Given to client	Version 2: November 19, 2021

Wyoming Department of Health

Aging Division

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

ERAP-HSS Service Plan (Non Project Based Services Only In This Section – Timetable of Services)		
Service	**Sub-Service**	**Service Plan Schedule Details Agreed Upon - Summary**
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	Information Technology Hardware – Delivery	
	Information Technology Hardware – Quarterly *(optional)*	
Independent Living Skills	Life Coaching	
	Money Management	
Hoarding Services	**Cleaning (n/a)**	
	Mental Health Counseling	

Documents/Forms for Specialized Services (Projects) and Dates of Completion Recorded			
Service	**Sub-Service**	**Minimum Forms Needed (Extras can be attached to Intake Form or Service Plan at sub recipient's discretion)**	**Frequency**
Home Modifications	n/a	__ Client Intake Form - Date:_____ __ Initial Evaluation & Project Planning - Date:_____ __ Client Service Plan - Date:_____ __ Letter of Project Approval from the Landlord - Date:_____ __ Final Evaluation - Date:_____	Once in Grant Period or Change of Status
Trailer/Mobile Home Repairs	n/a	__ Client Intake Form - Date:_____ __ Initial Evaluation & Project Planning - Date:_____ __ Client Service Plan - Date:_____ __ Final Evaluation - Date:_____	
Hoarding Services	Cleaning		
Personal Care – Skilled Nursing Services	RN / LPN / CNA	__ Client Intake Form - Date:_____ __ Client Service Plan - Date:_____ __ Nursing Assessment Form (Not provided by AGD) - Date:_____ __ Nursing Delegation Form (Not provided by AGD) - Date:_____	
All Other Services		__ Client Intake Form - Date:_____ __ Client Service Plan - Date:_____	
Description of Services Provided:			

Original: Stays with sub-recipient | Copy: Given to client | Version 2: November 19, 2021

Client's 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's 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.

Description of Services & Information (Additional Space if Required) Please Initial if Additional Page is Used/Attached: