



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) 90 th Day _____	End Date _____	Sub-recipient's Initials _____	Client's Initials _____
2) 90 th Day _____	End Date _____	Sub-recipient's Initials _____	Client's Initials _____
3) 90 th Day _____	End Date _____	Sub-recipient's Initials _____	Client's Initials _____
4) 90 th Day _____	End Date _____	Sub-recipient's Initials _____	Client's Initials _____
5) 90 th 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



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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 - <i>Wheelchair & Non-Wheelchair Accessible Vehicle</i>	
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 (<i>optional</i>)	
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: _____	
Hoarding Services	Cleaning	___ Client Service Plan - Date: _____ ___ Final Evaluation - Date: _____	
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:			



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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:

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