Aging Division – Community Living Section
National Family Caregiver Support Program (NFCSP)

Service Plan – Change of Status Form (CoS)

Date: _____ **Caregiver (CG) Name:**_____

DOB:_____ **Phone Number:** _____

Address: _____ **City:** _____, **WY Zip Code:** _____

Emergency Contact: _____ **Emergency Phone:** _____

Emergency Address: _____

Care Receiver (CR) Name: _____ **Relationship**_____

Evaluation Score: _____ **AGNES** ADL#_____ IADL#_____ **Service Plan Dates:** _____ through _____

SERVICE	SUB-SERVICE	FREQUENCY
Assistance Care Coordination	___ Evaluation Initial CG ___ Follow-Up CG & CR ___ Quarterly Evaluation CG & CR ___ Re-Evaluation Renewal CG ___ Evaluation Initial CR ___ Re-Evaluation Renewal CR	Initial Evaluation & Re-Evaluation: YEARLY or CHANGE OF STATUS Every 90 days Re-Evaluation
Counseling/Support Group/Training	__Counseling Caregivers __ Peer Support __ Support Group __ Training of Caregivers	
Respite	___ Adult Day Care ___ In-Home ___ Institutional ___ Assist Living	
Supplemental Services	___ Homemaking ___ Home Modifications ($400) ___ Assistive Devices ($400) ___ Assisted Transportation ___ Transportation ___ Meals ($5.25) ___ Incontinence Supplies ___ Chore/Handyperson ___ Personal Care ___ PERS- Personal ER Response System ___ Loan Closet	
Nursing Services: If Personal Care is indicated for the Care Receiver	___ Initial Assessment ___ Re-Assessment ___ Delegation ___ Medication Setup	YEARLY or CHANGE OF STATUS

Notes: _____

_____

By signing this Service Plan – Change of Status Form, I agree with the above plan of services; will participate in my services; and understand the consumer's rights and responsibilities. I will notify my Access Care Coordinator of any changes, needs, problems or complaints related to the provision of services. I understand that should I not receive services for 30 continuous days; that I may be discharged from the program. This information will not be shared with family/friends unless written permission is given. This information will be shared with the State of Wyoming.

_____ _____ _____ _____

Caregiver Signature: Date: ACC Signature: Date:

☐ Check box if verbal permission was received. ACC Signature: _____ Date: _____

*If verbal permission was received, the ACC must visit the client within 14 calendar days to review the form and obtain physical signature.

__ Original to Caregiver File __Copy to Caregiver __ Copy to A&D Personnel