



RIGHT FROM THE START PROJECT
CLIENT RIGHTS AND RESPONSIBILITIES



NAME: _____
(Last) (First) (MI)

SSN: _____

RIGHTS	RESPONSIBILITIES
<ul style="list-style-type: none"> To receive professional treatment and consideration. To participate in development of the care plan and selection of services. To choose the agency which will provide services agreed upon. To question any planned action. To decline any or all services offered. To withdraw from care coordination at any time without penalty or loss of any other program eligibility. To review or receive a copy of your RFTS records. To participate in RFTS any time during the eligibility period even if services have previously been refused. 	<ul style="list-style-type: none"> To keep all medical appointments. To keep all appointments for other services identified in the care plan and agreed upon by the client. To obtain all medically-ordered laboratory procedures. To report any change in address or telephone number. To report any changes in health condition. To report any changes in home environment which affect health condition. To provide Care Coordinator with a safe environment for visits.

TO REPORT ANY PROBLEMS OR CHANGES, PLEASE CALL: _____

If you believe you have been denied any of the above rights, you may contact the Right From The Start Project by phone at 1-800-642-8522 or mail at 350 Capitol Street, Room 427, Charleston, West Virginia 25301-3714.

CLIENT:

I have read and understand my responsibilities and rights and do hereby give permission for my/my infant's RFTS record to be released by the Care Coordinator to agencies participating in my care. I also give my permission for agencies participating in my/my infant's care to release information to the RFTS staff.

(Signature)

(Date)

DESIGNATED CARE COORDINATOR:

I have reviewed the rights and responsibilities with this client.

(Signature)

(Date)

CAREGIVER PERMISSION

I, _____ Parent/Guardian of _____
(Infant)
give permission to _____ to discuss and plan care for my infant in my absence
(Designated Care Coordinator)
with _____.
(Caregiver)

(Parent/Guardian Signature)

(Date)

(Designated Care Coordinator Signature)

(Date)

COMMENTS: _____

*Please identify additional person/persons who may be caregivers.