

West Virginia Department of Health and Human Resources  
**RIGHT FROM THE START PROGRAM**  
**CLIENT RIGHTS AND RESPONSIBILITIES**



**NAME:** \_\_\_\_\_ **SSN:** \_\_\_\_\_  
(Last) (First) (MI)

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

**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 Program 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  
with \_\_\_\_\_ (Designated Care Coordinator)  
(Caregiver)

\_\_\_\_\_  
(Parent/Guardian Signature) (Date)

\_\_\_\_\_  
(Designated Care Coordinator Signature) (Date)

**COMMENTS:** \_\_\_\_\_

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