**West Virginia Department of Health and Human Resources**

**RIGHT FROM THE START PROGRAM**

**CLIENT RIGHTS AND RESPONSIBILITIES**

<table>
<thead>
<tr>
<th>RIGHTS</th>
<th>RESPONSIBILITIES</th>
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<tbody>
<tr>
<td>• To receive professional treatment and consideration.</td>
<td>• To keep all medical appointments.</td>
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<tr>
<td>• To participate in development of the care plan and selection of services.</td>
<td>• To keep all appointments for other services identified in the care plan and agreed upon by the client.</td>
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<td>• To choose the agency which will provide services agreed upon.</td>
<td>• To obtain all medically-ordered laboratory procedures.</td>
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<td>• To question any planned action.</td>
<td>• To report any change in address or telephone number.</td>
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<td>• To decline any or all services offered.</td>
<td>• To report any changes in health condition.</td>
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<tr>
<td>• To withdraw from care coordination at any time without penalty or loss of any other program eligibility.</td>
<td>• To report any changes in home environment which affect health condition.</td>
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<tr>
<td>• To review or receive a copy of your RFTS records.</td>
<td>• To provide Care Coordinator with a safe environment for visits.</td>
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<tr>
<td>• To participate in RFTS any time during the eligibility period even if services have previously been refused.</td>
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**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 ____________________________________________ (Designated Care Coordinator) to discuss and plan care for my infant in my absence

with ____________________________________________ (Caregiver).

(Parent/Guardian Signature)  
(Date)

(Designated Care Coordinator Signature)  
(Date)

**COMMENTS:**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

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