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

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

RIGHTS	RESPONSIBILITIES
• 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.	• 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 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
(Designated Care Coordinator)
with _____.
(Caregiver)

_____
(Parent/Guardian Signature) (Date)

_____
(Designated Care Coordinator Signature) (Date)

COMMENTS:_____

_____

_____

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