
Client Name

Agency/Location

Consent or Refusal for Assessment

Yes No

I agree to have an assessment done. I understand that I might be able to get home care services instead of going to a nursing home. I understand if I do not agree to have an assessment I will not be able to receive home care services if I qualify.

Acceptance or Refusal of Services

Yes No

A plan of home care services has been discussed with me, my family or my representative. If I decide to accept the services that have been offered to me, my acceptance will be confirmed by phone, and I will receive a copy of the care plan. I have been offered a choice of service providers. I understand that I will be interviewed at least every six months as long as I agree to participate in the program.

I understand that if I decide not to accept the services, I will confirm my decision in writing. I may request to be rescreened for home care services in the future.

Program Requirements and Protections

I have been told that as a participant:

- Receipt of Program Information: The Program was explained to my satisfaction. I was given a program description, a copy of client's rights and responsibilities, and a copy of the Department's privacy policies.
- I must cooperate with all program requirements in order to continue my services. I will notify the Department of Social Services and my care manager of all income, asset and living arrangement changes within ten (10) days of the change.
- All information I provided on the Eligibility Determination Document is subject to verification by state officials.
- I may have to contribute towards the cost of my services and any fees will be explained to me.
- In some cases, the Department may pursue legally liable relative contributions from spouses of recipients receiving services under this program.
- The State also has the right to recover monies from the estates of individuals who receive services from this program.
- I will be assisted in every way possible to find out if I am eligible for other programs benefits and services.

I understand I have the right to ask for a review of the assessment done or the plan of services offered to me by telling my Care Manager or calling the program toll-free number 1-800-445-5394. I also understand that if I am still not satisfied with the decision, I can request a hearing from the Department within sixty (60) days from the date of this notice. A request for a hearing must be made in writing and addressed to the State of Connecticut, Department of Social Services, Office of Legal Counsel, Regulations and Administrative Hearings, 25 Sigourney Street, Hartford, CT 06106-5033. For more information about hearings, you may call (860) 424-5760 or toll-free at 1-800-462-0134.

I further understand that if I believe I have been treated unfairly because of race, color, religious creed, sex, marital status, age, national origin, ancestry, criminal record, political beliefs, sexual orientation, mental retardation, mental disability, learning disability or physical disability, including but not limited to blindness, I or someone representing me may write to or call one or more of these agencies to make a discrimination complaint: Commissioner of the Department of Social Services, Attention Affirmative Action Division Director/ADA Coordinator, 25 Sigourney Street, Hartford, CT 06106-5033, or call 1-860-424-5040 (TDD: 1-800-842-4524); Connecticut Commission on Human Rights and Opportunities, 21 Grand Street, Hartford, CT 06106, or call 1-860-541-3400 (TDD: 1-860-541-3459); or the U.S. Department of Health and Human Services, Director, Office of Civil Rights, Region 1, JFK Federal Building, Room 1875, Boston, MA. 02203, or call 1-617-565-1340 (TDD: 1-617-565-1343).

Acceptance of Services

Yes

No

_____ (Date)

_____ (Staff Initials)

Comments: _____

_____ Date

_____ Client's Signature or Mark (X)

_____ Date

_____ Witness' Signature if signed with an (X)

_____ Date

_____ Authorized Representative's Signature

_____ Date

_____ Care Manager/Other Health Professional