



**HOT SPRINGS COUNTY SENIOR CITIZENS CENTER, INC.**  
**NON-SENIOR INTAKE FORM**

Date \_\_\_\_\_

Name \_\_\_\_\_  
FIRST MI LAST

Mailing Address \_\_\_\_\_ Street Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number(s) ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME CELL

Email Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_

**RELEASE OF INFORMATION**

I hereby give my permission for Hot Springs County Senior Citizens Center, Inc. to share information contained in the NON-SENIOR INTAKE and other program documentation with the Aging Division and other affiliated service providers for the purpose of eligibility for the Administration on Aging and State of Wyoming grant programs such as supportive services, congregate meals, home delivered meals, preventive services, community in-home services, transportation, family caregiver services.

Further, I understand that: By agreeing to take part in this program I give my permission to the service provider(s), Wyoming Department of Health (WDH), Aging Division, and the Administration on Aging (AoA) to share information obtained for the purpose of program evaluation and oversight.

Information received will be treated as confidential and will only be made available in accordance with the requirements of law.

I may cancel this release at any time except to the extent that action has been taken in reliance on it, and that in an event this release expires automatically one year from the date of my signature.

If I do not sign this release for the purposes described above, I may be required to pay for any services I have received or be solely responsible for payment of services.

If I am denied program services, I may be entitled to a hearing.

I have the right review and/or obtain a copy of my record including an accounting of any disclosures made from my record.

If I feel information in my record is invalid, I may make a written request for an amendment of the record. I have been provided a copy of this form.

If I feel I have been treated inappropriately, services have not been of the quality expected and/or not provided as stated in the service plan; I may contact the Wyoming Long Term Care Ombudsman at (800) 856-4398 or the WDH Aging Division at (800) 442-2766. For additional information regarding the Wyoming Department of Health's privacy policy, visit the WDH Department's HIPAA website: <http://www.health.wyo.gov/main/hipaa.html> or call DeAnna Coates, WDH HIPAA Compliance Officer at (307) 733-8664.

Client or Representative's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Authority and Relationship of Representative (if any) to sign on Client's behalf \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_