AAA-1247A FORFF (6-14)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

RESET

SHORT FORM INTAKE DOCUMENT (SFID)

☐ NEW ☐ REASSESSMENT ☐ CHANGE ☐ REVIEW ☐ CLOSE	ASSESSMENT DATE	DAARS ID NO.

PART I: INTAKE INFORMATION

A. Client Profile and Referral Information

FIRST NAME	LAST NAME	M.I.	SOC. SEC. NO.	DATE OF BIRTH

PHONE NO. 1	☐ HOME ☐ WORK ☐ CELL ☐ FAX ☐ CAR ☐ OTHER	PHONE NO. 2	☐ HOME ☐ WORK ☐ CELL ☐ FAX ☐ CAR ☐ OTHER

HOME OR RESIDENCE ADDRESS *(No., Street, Apt. No., City, State, ZIP)*	MAILING ADDRESS *(P.O. Box, Street, City, State, ZIP)*
VALID DATES From To	VALID DATES From To
E-MAIL ADDRESS 1 ☐ PERSONAL ☐ WORK ☐ OTHER	E-MAIL ADDRESS 2 ☐ PERSONAL ☐ WORK ☐ OTHER
☐ Yes ☐ No Needs emergency evacuation assistance *(based on responses in Part IV)*.	☐ Yes ☐ No Is a primary caregiver (informal) assisting you?

INFORMATION FOR INTERVIEW WAS OBTAINED FROM
☐ Self report ☐ Medical records ☐ Other *(specify)*

NAME OF REFERRAL SOURCE	REFERRAL SOURCE PHONE NO.	REFERRAL DATE

REFERRAL SOURCE ADDRESS *(No., Street, Apt. No., City, State, ZIP)*

REFERRAL SOURCE TYPE

☐ Self	☐ Hospital	☐ Senior center
☐ Family	☐ Agency	☐ AHCCCS health plan
☐ Friend	☐ Residential facility	☐ AHCCCS – ALTCS
☐ Physician	☐ APS	☐ Other

LOCATION AT TIME OF REFERRAL ☐ Hospital ☐ Emergency room ☐ Community ☐ LTC facility	ADMISSION DATE	DISCHARGE DATE

ELIGIBILITY CATEGORY
☐ 60 and over
☐ Spouse of client age 60 and over
☐ Under 60 with a disability
☐ Caregiver of eligible client

ELIGIBLE CLIENT *(associated with spouse or caregiver)*
NAME
SOC. SEC. NO.

B. Demographics

TYPE OF DISABILITY

☐ Physical	☐ Traumatic brain injury
☐ Intellectual disability/developmental disability (ID/DD)	☐ Dementia
☐ Mental illness	☐ Other *(specify)* _____
	☐ None

ETHNICITY
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declined to state

RACE	RELATIONSHIP STATUS	LANGUAGE
☐ Asian	☐ Divorced	☐ English
☐ Black/African American	☐ Domestic partner	☐ American Indian (w/Eng)
☐ Native Hawaiian or other Pacific Islander	☐ Married	☐ American Indian (w/o Eng) *(specify)*:_____
☐ American Indian or Alaskan Native	☐ Separated	☐ Spanish (w/Eng)
☐ White	☐ Single	☐ Spanish (w/o Eng)
☐ Other	☐ Widowed	☐ Other *(specify)*: _____
☐ Declined to state	☐ Declined to state	☐ Declined to state

ENGLISH FLUENCY	EDUCATION
☐ Fluent	☐ Grade school or less
☐ Limited	☐ Some high school
☐ Needs translation	☐ High school graduate
☐ Declined to state	☐ Post high school
	☐ College degree
	☐ Declined to state

CLIENT'S NAME	DAARS ID NO.

RESIDENCE TYPE
- ☐ Apartment
- ☐ Assisted living facility
- ☐ Board and care
- ☐ DD group home
- ☐ Foster care
- ☐ House
- ☐ Mobile
- ☐ Nursing home
- ☐ Other (specify): _____
- ☐ Declined to state

LIVING ARRANGEMENT
- ☐ No pay
- ☐ Owns
- ☐ Rents
- ☐ Subsidized
- ☐ N/A
- ☐ Declined to state

NUMBER IN HOUSEHOLD

HOUSEHOLD COMPOSITION
- ☐ Institutionalized
- ☐ Lives alone
- ☐ With domestic partner
- ☐ With non-relative(s)
- ☐ With other relative(s)
- ☐ With parent(s)
- ☐ With spouse
- ☐ Other *(specify)*: _____
- ☐ Declined to state

LENGTH OF TIME AT PRESENT ADDRESS

_____ Years _____ Months

URBAN/RURAL
- ☐ Rural
- ☐ Urban
- ☐ Declined to state

SEX / GENDER
- ☐ Female
- ☐ Male
- ☐ Unknown

TRANSGENDER *(optional)*
- ☐ Yes
- ☐ No
- ☐ Declined to state

SEXUAL ORIENTATION *(optional)*
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Declined to state

VETERAN
- ☐ No
- ☐ Child
- ☐ Spouse
- ☐ Veteran
  Veteran #: _____
- ☐ Declined to state

LEGAL STATUS
- ☐ Independent
- ☐ Child
- ☐ Conservator
- ☐ DP7 payee
- ☐ Guardian
- ☐ LTC payee
- ☐ Other *(specify)*: _____
- ☐ Declined to state

C. Contacts

Close Contacts

EMERGENCY CONTACT	RELATIONSHIP	ADDRESS	PHONE	E-MAIL
NEXT OF KIN				
SIGNIFICANT OTHER/SPOUSE				
LIVES WITH				
USUAL CONTACT				
OTHER				
OTHER				

Medical Contacts *(if applicable)*

PRIMARY PHYSICIAN	FIELD	ADDRESS	PHONE	E-MAIL
SOCIAL WORKER				
HOMECARE AIDE				

Assessment Contacts *(if applicable)*

DP7 CONTACT	RELATIONSHIP	ADDRESS	PHONE	E-MAIL
DURABLE POWER OF ATTORNEY FOR HEALTHCARE (DPOAH)	RELATIONSHIP			
REFERRAL SOURCE				
HANDLING FINANCIAL MATTERS				
OTHER				

CLIENT'S NAME	DAARS ID NO.

D. Net Monthly Income Information

	CLIENT	SPOUSE/HOUSEHOLD	TOTAL
Earned income			
Retirement/pension			
Investment income			
Social Security			
Supplemental Security Income (SSI)			
Veterans compensation			
Veterans pension			
Veterans aid & attendance (A&A)			
Other			
Total monthly income	TOTAL CLIENT INCOME	TOTAL SPOUSE/HOUSEHOLD INCOME	COMBINED TOTAL INCOME

At or below 100% FPL ..... ☐ Yes ☐ No ☐ Declined to state income

E. Monthly Expenses

	CLIENT	SPOUSE/HOUSEHOLD	TOTAL
Housing			
Food			
Utilities			
Medical			
Insurance			
Private pay assistance			
Transportation			
Other			
Total monthly expenses	TOTAL CLIENT EXPENSES	TOTAL SPOUSE/HOUSEHOLD EXP	COMBINED TOTAL EXPENSES
		Subtract Total Expenses from Total Income above and enter the **Total net income after expenses**	

F. Insurance Information

MEDICARE NUMBER	ENROLLMENT DATE *(optional)*	QMB	SLMB
		☐ Yes ☐ No	☐ Yes ☐ No

MEDICARE PARTS
☐ A EFFECTIVE DATE: _____ ☐ B EFFECTIVE DATE: _____ ☐ D EFFECTIVE DATE: _____

AHCCCS / ALTCS NUMBER	AHCCCS PLAN NAME

COUNTY CODES *(OPTIONAL)*	INSURANCE/BENEFITS	VETERANS MEDICAL BENEFITS	HAS MEDICARE ADVANTAGE PLAN
		☐ Yes ☐ No	☐ Yes ☐ No

G. Legal Planning

DURABLE POWER OF ATTORNEY

Financial ..... ☐ Yes ☐ No
Health ..... ☐ Yes ☐ No
Mental health ..... ☐ Yes ☐ No

Living will ..... ☐ Yes ☐ No
DNR (Orange form) ..... ☐ Yes ☐ No
Burial arrangements, mortuary ..... ☐ Yes ☐ No

CLIENT'S NAME	DAARS ID NO.

NAME OF PERSON WHO WILL BE HANDLING YOUR FINANCIAL MATTERS	RELATIONSHIP	TYPE
		☐ Self ☐ Family ☐ DPOA ☐ Rep payee ☐ Other ☐ Conservator

PART II: CAREGIVER INFORMATION

Is there a primary caregiver (informal) assisting you? ..... ☐ Yes ☐ No *(if No, go to the next section of the assessment)*

CAREGIVER'S NAME *(Last, First, M.I.)*	PHONE NO.
ADDRESS *(No., Street, City, State, ZIP)*	E-MAIL ADDRESS

GENDER	RACE	ETHNICITY	URBAN/RURAL
☐ Male ☐ Female ☐ Declined to state	☐ Asian ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaskan Native ☐ White ☐ Other ☐ Declined to state	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to state	☐ Rural ☐ Urban ☐ Declined to state

RELATIONSHIP TO CARE RECIPIENT	LENGTH OF TIME PROVIDING CARE
☐ Husband ☐ Wife ☐ Domestic partner ☐ Daughter/daughter-in-law ☐ Son/son-in-law ☐ Grandparent ☐ Other relative ☐ Non-relative	☐ Less than one year ☐ 1-2 years ☐ 3-5 years ☐ 6-10 years ☐ 11 or more years

Does the caregiver reside with the recipient? ..... ☐ Yes ☐ No

Would the caregiver and care recipient be interested in more information about FCSP? ..... ☐ Yes ☐ No

PART III: NUTRITIONAL STATUS

Does the client have a special diet? ..... ☐ Yes ☐ No If Yes, specify: _____

Does the client have a food allergy? ..... ☐ Yes ☐ No If Yes, specify: _____

Nutritional Screening *(Check all that apply and total the score shown for each selected response.)*

- ☐ I have an illness or condition that made me change the kind and/or amount of food I eat. (2)
- ☐ I eat fewer than 2 meals per day. (3)
- ☐ I eat few fruits or vegetables or milk products. (2)
- ☐ I have 3 or more drinks of beer, liquor or wine almost every day. (2)
- ☐ I have tooth or mouth problems that make it hard for me to eat. (2)
- ☐ I don't always have enough money to buy the food I need. (4)
- ☐ I eat alone most of the time. (1)
- ☐ I take 3 or more different prescribed or over-the-counter drugs a day. (1)
- ☐ Without wanting to, I have lost or gained 10 pounds in the last 6 months. (2)
- ☐ I am not always physically able to shop, cook and/or feed myself. (2)

TOTAL SCORE *(0-2 is good, 3-5 is moderate nutritional risk, 6 or greater is high nutritional risk)*	HEIGHT *(Optional)*	WEIGHT *(Optional)*

COMMENTS

PART IV: BASIC FUNCTIONAL ASSESSMENT

A. Orientation *(Check appropriate answer. Consider last 90 days.)*

Orientation is defined as the client's awareness of his/her environment in relation to time, place and self.

Person (identification of self).

- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

CLIENT'S NAME	DAARS ID NO.

Place (immediate environment, residence, city, state).

- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

Time (day, month, year, time of day).

- ☐ Disoriented occasionally (3 times or less per month).
- ☐ Disoriented some of the time (more than 3 times per month but less than half the time).
- ☐ Disoriented at least half the time.
- ☐ No problems with orientation.

Recent memory recall.

- ☐ Minimally impaired function.
- ☐ Moderately impaired function.
- ☐ Severely impaired function and safety.
- ☐ No problem with memory recall.

COMMENTS

B. Communication/Sensory *(Check appropriate answer. Consider last 30 days.)*

Hearing – The ability to perceive sounds (with hearing appliance, if used).

- ☐ Minimal difficulty (e.g., understands conversation when face to face).
- ☐ Hears in special situations only (e.g., speaker has to adjust tonal quality and speak distinctly), will only understand loud conversation.
- ☐ Absence of useful hearing (e.g., will hear only very loud voice; totally deaf).
- ☐ Hears adequately (e.g., conversation, TV, phone).

Expressive Communication – The ability to express information and making self understood using any means (making self understood by others).

- ☐ Difficulty finding words, finishing thoughts, or enunciating.
- ☐ Ability is limited to making concrete requests.
- ☐ Rarely/never understood.
- ☐ Understood.

Vision – The ability to perceive visual stimuli (with corrective devices, if used).

- ☐ Difficulty with focus at close (reading) range. Sees large print and obstacles, but not details or has monocular vision.
- ☐ Unable to see large print, field of vision is severely limited (e.g., tunnel vision or central vision loss).
- ☐ No vision or appears to see only light, colors or shapes.
- ☐ Sees adequately (e.g., newsprint, TV, medication labels).

Smell – The ability to perceive odors/scents, especially odors indicating a danger (e.g., smoke).

- ☐ Impairs safety.
- ☐ Does not impair safety.

Touch – The ability to discriminate against temperature (e.g., hot, cold), dull and sharp, and pain (e.g., resulting from an open wound).

- ☐ Impairs safety.
- ☐ Does not impair safety.

COMMENTS

CLIENT'S NAME | DAARS ID NO.

C. Assessment of Daily Living Activities

For each activity, select the level of assistance needed, select the source of help, and select the qualifier, as needed.

Levels of Assistance

1. **Ind**ependent – Completes the task independently.
2. **Min**imum Assistance – Occasional assistance or supervision may be necessary.
3. **Mod**erate Assistance – Assistance or supervision is usually necessary.
4. **Max**imum Assistance – Totally dependent on others.

Qualifiers

C – Cognitive
I – Isolation
S – Safety

Source of Help

a. None
b AAA provided
c. Daughter
d. Friend
e. Other relative
f. Parent
g. Private paid help
h. Publicly funded help
i. Residential health care
j. Sibling
k. Son
l. Spouse/significant other
m. Volunteer

Activities of Daily Living

	1. Ind	2. Min	3. Mod	4. Max	Source of Help	Qualifiers	Comments
Bathing	☐	☐	☐	☐			
Dressing	☐	☐	☐	☐			
Eating	☐	☐	☐	☐			
Walking	☐	☐	☐	☐			
Transferring	☐	☐	☐	☐			
Toileting	☐	☐	☐	☐			

Instrumental Activities of Daily Living

	1. Ind	2. Min	3. Mod	4. Max	Source of Help	Qualifiers	Comments
Shopping for personal items	☐	☐	☐	☐			
Doing heavy housework	☐	☐	☐	☐			
Doing light housework	☐	☐	☐	☐			
Using the telephone	☐	☐	☐	☐			
Managing money	☐	☐	☐	☐			
Transportation ability	☐	☐	☐	☐			
Preparing meals	☐	☐	☐	☐			
Medication management	☐	☐	☐	☐			

COMMENTS

D. Assistive Devices

For the following devices, select *Has* or *Needs* the device. If client does not have or need any device, select None. **Restore List**

	Has	Needs		Has	Needs		Has	Needs
Cane	☐	☐	Hoyer lift	☐	☐	Mediset	☐	☐
Quad cane	☐	☐	Shower bench	☐	☐	Glucometer	☐	☐
Crutches	☐	☐	Shower chair	☐	☐	Test strips	☐	☐
Walker	☐	☐	Raised toilet seat	☐	☐	Dentures	☐	☐
Electric wheelchair	☐	☐	Commode chair	☐	☐	Hearing aids	☐	☐
Manual wheelchair	☐	☐	Hand-held shower	☐	☐	Eye glasses	☐	☐
Electric scooter	☐	☐	Geri-chair	☐	☐	Service dog	☐	☐
Hospital bed	☐	☐	Grab bars	☐	☐	Emergency notification	☐	☐
Egg crate mattress	☐	☐	Oxygen	☐	☐	Communication board	☐	☐
Hand rails	☐	☐	Oxygen mask	☐	☐	Companion animals	☐	☐
Side rails half	☐	☐	Nasal prongs/cannula	☐	☐	Assistive phone device	☐	☐
Side rails full	☐	☐	Concentrator	☐	☐	Other assistive device *(specify in comments)*	☐	☐
Trapeze	☐	☐	Portable oxygen	☐	☐			
Transfer board	☐	☐	Ventilator	☐	☐	None	☐	

CLIENT'S NAME	DAARS ID NO.

COMMENTS

E. Evacuation Needs Assessment

Evacuation Needs Assessment Instructions

1. Was the response to ASCAP Part I, Section B, question Household Composition identified as "Lives Alone"?
   - ☐ Yes (go to question #2)
   - ☐ No (go to question #3, select "No")
2. Which of the following items have been identified on the ASCAP? (Check the appropriate box(es).)
   - ☐ ASCAP Part IV, Sec. C, **Transportation** is identified as 3. Mod. Asst. OR 4. Max. Asst., OR the Qualifier "Cognitive" is identified.
   - ☐ ASCAP Part IV, Sec. C, **Transferring** is identified as 3. Mod. Asst. OR 4. Max. Asst., OR the Qualifier "Cognitive" is identified.
   - ☐ ASCAP Part IV, Sec. B, **Hearing** is identified as "Absence of useful hearing."
   - ☐ ASCAP Part IV, Sec. B, **Vision** is identified as "No vision or appears to see only light, colors or shapes."
   - ☐ ASCAP Part IV, Sec. A, **Person**, **Place**, **Time** and/or **Recent memory recall** are identified as "Disoriented at least half of the time" or "Severely impaired function and safety."
   - ☐ ASCAP Part IV, Sec. D, One or more of these items, **Cane, Quad Cane, Crutches, Walker, Electric wheelchair, Manual wheelchair, Electric scooter, Oxygen, Oxygen mask, Portable oxygen** or **Ventilator**, is identified as "Has."

   If one or more of these items are checked, go to question #3 and select "Yes".
   If no items are checked, go to question #3 and select "No".
3. In the event of a disaster/emergency where evacuation is required, would the individual be placed on a priority list for evacuation assistance?
   - ☐ **Yes** (Case Manager: If you are satisfied with this answer, go to question #4. If you feel that "No" would be a better answer, select the override box and provide an explanation.)
   - ☐ **No** (Case Manager: If you are satisfied with this answer, **STOP – Process Ends.** Go to Part I, Sec. A, Client Profile of this assessment and mark "No" to "Needs emergency evacuation assistance." If you feel that "Yes" would be a better answer, select the override box and provide an explanation.)
   - ☐ **Override:** Select this box if, in the judgment of the Case Manager, the answer to question #3 should be changed. Explain why an override of the automatic answer is warranted.

   If you selected the override, changing "Yes" to "No," **STOP – Process Ends.** Go to Part I, Sec. A, Client Profile of this assessment and mark "No" to "Needs emergency evacuation assistance."

   If you selected the override, changing "No" to "Yes", go to question **#4**.
4. In the judgment of the Case Manager, and if resources are available during a disaster/emergency requiring evacuation, describe what evacuation assistance would be required for the individual. Then go to Part I, Sec. A, Client Profile of this assessment and mark "Yes" to "Needs emergency evacuation assistance."

PART V: ADDITIONAL FUNCTIONAL ASSESSMENT

This section intentionally blank. It is not required for the SFID.

PART VI: UNMET NEEDS

This section intentionally blank. It is not required for the SFID.

CLIENT'S NAME	DAARS ID NO.

PART VII: SERVICE ENROLLMENTS

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

CLIENT'S NAME	DAARS ID NO.

PART VIII: AUTHORIZATION

Authorization / Autorización

_____ I have received a copy of the Client Rights and Responsibilities and I certify by my signature or mark that I understand my rights and responsibilities, and that the information provided on this form, as it relates to my request and eligibility, is true and correct.

He recibido una copia del folleto Derechos y Responsabilidades del Cliente y atestiguo por mi firma o marca que entiendo mis derechos y responsabilidades y que la información provista en este formulario como se relaciona a mi petición y mi elegibilidad es verdadera y correcta.

_____ The service plan has been discussed with me and I agree with the described services. I have received a copy of the grievance and appeals procedure, and I understand that if I disagree with any action taken in my case, I have the right to present a verbal or written request for a fair hearing.

Me han explicado el plan de servicios y estoy de acuerdo con los servicios descritos. He recibido una copia del procedimiento de quejas y entiendo que si no estoy de acuerdo con cualquiera acción tomado en mi caso, que yo tengo el derecho a presentar una solicitud verbal o por escrito de una audiencia imparcial.

_____ I was provided the opportunity to contribute voluntarily to the cost of services.

Se me proporcionó la oportunidad de contribuir de manera voluntaria al costo de los servicios.

Client's Signature or Mark / Firma o marca del cliente		Date / Fecha
Responsible Party's Signature / Firma del parte responsable	Relationship / Afinidad	Date / Fecha
Worker's Name / Nombre del trabajador	Worker's Signature / Firma del trabajador	Date / Fecha