Wyoming Department of Health

PUBLIC HEALTH DIVISION

RURAL AND FRONTIER HEALTH

WYOMING DEPARTMENT OF HEALTH, COMMUNITY SERVICES PROGRAM
122 West 25th Street, Suite 102E, Cheyenne, WY 82002
(307) 777-8940

empowOR Client Basic Information

Client Name:	
Address:	
Housing Status:	☐ Homeowner ☐ Rent ☐ Unhoused ☐ Other Permanent Housing ☐ Other
Marital Status:	☐ Divorced ☐ Married ☐ Separated ☐ Widowed ☐ Never Married/Single

Household Member Name(s)	Relation to Client	DOB	Gender	Race	Disability	Veteran Status
	SELF					

Family Type:	☐ Single Person ☐ Two Adults no Children ☐ Two Parent Family ☐ Female-headed Single Parent ☐ Male-headed Single Parent ☐ Non-related Adults with Children ☐ Multi-generational Household ☐ Other

Household Member Name(s)	Education History	Employment Status	Health Insurance

Youth (14-24yo) Not in School/Not Working:	

Household Member Name(s)	Income Source(s)	Amount & Frequency	Benefits

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Household Member Name(s)	Income Source(s)	Amount & Frequency	Benefits
Assistance Request:			
Referrals:			

The information I have provided above is true, accurate, and complete to the best of my knowledge. I certify that a full account of all household income for at least the last 30 days and any appropriate income documents have been provided. I understand that providing false, incomplete, or misleading information may disqualify me from receiving services. I also understand that I must alert the agency to changes in my employment and income status and that any such changes may affect my eligibility for CSBG services.

Client Signature _____ **Date** _____

EmpowOR Status Options

Disability:	1. Disabled 2. Developmental Disability 3. Mental Disability	4. Physical Disability 5. Not Disabled
Veteran Status:	1. Active Duty 2. Veteran	3. Never Served in Military
Education:	1. < 9yrs (0-8th Grade) 2. 9-12th Grade (Non-Graduate) 3. High School Graduate 4. GED/Equivalent	5. 12+ (Some Post Secondary) 6. 2-to-4-year College Graduate 7. Graduate of Other Post-secondary School
Employment Status:	1. Employed Full Time 2. Employed Part Time 3. Not in labor force	4 Retired 5. Unemployed ≤6 months 6. Unemployed >6 months
Health Insurance:	1. No Health Insurance 2. Insured Employer Provided 3. Insured-Medicaid 4. Medicare 5. Military Health Care	6. Private/Out of Pocket 7. SCHIP 8. State Health Insurance for Adults 9. Insured - Unknown Type

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CLIENT INCOME CERTIFICATION &

DECLARATION OF ZERO HOUSEHOLD INCOME

Notice of Privacy Practices:

You have the right to a copy of the Notice of Privacy Practices, which describes how WDH may use and disclose your protected health information. A copy of this notice is available upon request and can be found on the Wyoming Department of Health website at https://health.wyo.gov/admin/privacy/notice-privacy-practices/.

Select One

Income Certification:

☐ Income for all household members over the age of 18 has been provided.

List all incomes from snapshot, 1/line

Declaration of Zero Household Income:

☐ The household has had no source of income.

I have been able to maintain my basic necessities by: _____

_____

The information I have provided in my application for services is true, accurate, and complete to the best of my knowledge. I certify that a full account of all household income for at least the last 30 days and any appropriate income documents have been provided. I understand that providing false, incomplete, or misleading information may disqualify me from receiving services. I also understand that I must alert the agency to changes in my employment and income status and that any such changes may affect my eligibility for CSBG services.

_____ _____

Client Signature Date

Council of Community Services

"helping people help themselves"

CSBG BLOCK GRANT MEDICAL/DENTAL SURVEY

Date_____

Name_____

____ Medical Appointment ____ RX ____ Dental Appointment

Condition Requiring Service:

_____

What does this condition prevent you from doing?

_____

Signature_____

For Office Use:

Date Voucher Issued: _____

Date of Payment: _____

30 day follow up:

Date_____

How has this service improved client's health and well-being? _____

_____

Staff Signature_____

Campbell County
wyoming
CARE Board

Campbell County CARE Board Client Satisfaction Survey

The CARE Board's mission is to support local agencies and non-profit organizations to reduce poverty through community action by facilitating collaboration, advocacy, resources, and education.

Thank you for your feedback! This survey is confidential and helps us to improve our services.

Service Provider: _____

Date(s) of Service: _____ Services Received: _____

The services I received met my needs.

Strongly disagree | Disagree | neutral | Agree | Strongly agree

Please explain how the services met your needs.

As a result of the services I received, I feel more stable in my situation.

Strongly disagree | Disagree | neutral | Agree | Strongly agree

The staff/volunteers helped me make progress toward my goals.

Strongly disagree | Disagree | neutral | Agree | Strongly agree

I trust the staff/volunteers that I interacted with.

Strongly Disagree | Disagree | neutral | Agree | Strongly agree

The services were provided within a reasonable timeframe.

Strongly disagree | Disagree | neutral | Agree | Strongly agree

Overall, I am satisfied with the services i recieved

Yes

No

Please share any additional comments or suggestions on how we can improve our services.