Long Term Home Health Care Program (LTHHCP)
AIDS Home Care Program (AHCP)

Consumer Contact Information

NAME: _____ CIN#: _____ DATE: _____

☐ New Application: ☐ Reassessment:

From the available LTHHCP Agencies, I have selected the following:

Agency Name _____

Agency Address _____

Agency Phone # _____

Local Department of Social Services (LDSS)

Contact Name: _____

Phone # _____

Home Health Hotline Phone Number: **800-628-5972**

This toll free number may be used by you, your family or anyone to lodge a complaint regarding the quality of care or any type of complaint regarding home care services.

Your plan of care is based on an assessment by the LDSS and the LTHHCP agency and approved by your doctor. You, your family/representative or designated other may participate in developing the plan of care and choose the services necessary for your plan of care.

I have participated in the development and agree with my plan of care.

Signature of LTHHCP participant/legal guardian *Date*