**INFORMED CONSENT FORM**

**ENROLLEE NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**An assessment is required for all persons applying for or receiving assistance for**

**long-term care. This includes the Institutional Care Program (ICP) and Home and**

**Community-Based Services (HCBS) waiver programs.**

**In order to evaluate my needs, I consent to the following:**

* **I agree to an assessment to identify my need for long-term care, and to determine if my needs can be met in the community instead of a nursing facility.**
* **I authorize the Department of Elder Affairs’ (DOEA) staff to access my medical records. I understand and agree that the DOEA may need to talk to my doctor and other health professionals. I also understand that they may need to interview my family members, close friends and social services professionals about my situation.**

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**Enrollee or Enrollee’s Representative**

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**Relationship (if representative signs)**

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**Date**