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. **For the Department of Elder Affairs (DOEA) 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 DOEA staff to access my medical records to include documents related to sensitive health conditions involving: drug, alcohol or substance abuse, psychological or psychiatric treatment, HIV/AIDS and/or sexually transmitted diseases. I understand and agree that the DOEA may need to speak with my medical provider 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.
- This authorization will remain in effect, unless revoked in writing, for the duration of applying for or receiving long-term care services.

I hereby acknowledge that I have received notification of DOEA's Notice of Privacy Practices available at www.elderaffairs.org/about-us/hipaa/notice-of-privacy-practices, and understand a hard copy is available upon request.

______________________________________	______________________________________
Enrollee or Enrollee's Representative	**Relationship (if representative signs)**

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Date