STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
DEPARTMENT OF ELDER AFFAIRS

INFORMED CONSENT FORM

CLIENT'S NAME: _____

SOCIAL SECURITY # - _____

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 am giving my 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 DC&F and DOEA staff to access my medical records. I understand and agree that DC&F and DOEA may need to talk to my doctor and other health professionals. I also understand that they may need to interview family members, close friends and social services professionals about my situation.**

_____
Individual or Representative

_____
Relationship (if representative signs)

_____
Date