STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)
DEPARTMENT OF ELDER AFFAIRS (DOEA)

INFORMED CONSENT FORM

CLIENT'S 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 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 DOEA staff to access my medical records. I understand and agree that 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.**

_____
Individual or Representative

_____
Relationship (if representative signs)

_____
Date