WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING
WYOMING MEDICAID
PASRR LEVEL II INFORMED CONSENT FORM

NAME:
SOCIAL SECURITY #:

The Level II PASRR determination notices are adapted to the race, ethnicity, language, and means of communication used by the individual being evaluated.

Please fill in the following:

RACE:
ETHNICITY:
PRIMARY LANGUAGE:
PREFERRED METHOD OF COMMUNICATION (Written, oral, sign, etc.):

An assessment is required for all persons applying for or receiving assistance for long term care. 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 Wyoming Department of Health (WDH) and Telligen program staff to access my medical records. I understand and agree that WDH and Telligen 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.
- I authorize a qualified clinician (as defined per Wyoming State Statute, Wyoming Medicaid Program Manual, Community Mental Health Manual, Chapter 2, Section 01) to conduct a Psychosocial Evaluation and allow said clinician to access my medical records. I understand and agree that the clinician 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 Signature	Date:
(Indicate Relationship if signed by Representative):	
Please enter Contact Information below (address, phone, fax, email):	