State of Alaska • Department of Health and Social Service • Senior and Disabilities Services

Inventory for Client and Agency Planning (ICAP) Assessment Information and Consent

Please refer to the *Guidelines for the ICAP Process* for assistance in providing the required information

Applicant/participant: _____

New ☐ OR ☐ Renewal IDD ☐ OR ☐ TEFRA

Physical address: _____
Street City State

Mailing address: _____
Street City State Zip

Telephone: _____ Medicaid number: _____

Agencies serving applicant/participant: _____

_____

Residential facility (if applicable): _____

Care Coordinator: _____ Agency: _____ Telephone: _____

☐ Legal Guardian ☐ Parent Name: _____ Telephone: _____

Current medications: Purpose:

***Respondents*:**

Name: _____ Telephone: _____

Relationship: _____ Needed accommodation: _____

Name: _____ Telephone: _____

Relationship: _____ Needed accommodation: _____

Name: _____ Telephone: _____

Relationship: _____ Needed accommodation: _____

Attachments:
- ☐ Current release of information for each respondent
- ☐ Supportive diagnostic information (if not attached, date of future evaluation)
- ☐ Police reports/legal information
- ☐ Interdisciplinary Team *Evaluation Report*
- ☐ Current behavior management plan
- ☐ Other: _____

Comments/or alternate respondents: _____

_____

_____

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Consent for Administration of the Inventory for Client and Agency Planning (ICAP)

Applicant/participant: _____

Initial each line and sign below

_____ My care coordinator has explained, and I understand the information provided in the *Guidelines for the ICAP Process.*

_____ I have received the *Guidelines for the ICAP Process*

_____ I understand that the responses provided by my ICAP Respondents must be accurate and will be used in assessing eligibility for a Medicaid waiver.

_____ I understand that the applicant listed above may or may not meet the eligibility criteria for a Medicaid waiver.

_____ I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ I consent to a Senior and Disabilities Services representative conducting the ICAP assessment for the applicant/participant listed above.

_____ _____

Signature of applicant/participant or Representative Date

_____

Printed name of applicant/participant or Representative