WYOMING DEPARTMENT OF HEALTH
OFFICE OF HEALTHCARE FINANCING
WYOMING EQUALITYCARE

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: _____
PERFERRED METHOD OF COMMUNICATION: _____

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 APS Healthcare staff to access my medical records. I understand and agree that WDH and APS 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) & Contact Information (address, phone, fax, email)

_____
Data