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: ____

PERFERRED METHOD OF COMMUNICATION (Written, oral, sign, etc.)

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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 Xerox Care and Quality Solutions (CQS) staff to access my medical records. I understand and agree that WDH and CQS 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)

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Please enter Contact Information above (address, phone, fax, email)