Applicant/Consumer _____ SAMS ID# _____

ASAP Name and Contact Info

Applicant Consent and Disclosure Form

In order to provide Home Care Services under the Massachusetts Home Care Program, the Aging Services Access Point (ASAP) must collect personal and health information to establish your eligibility for services and coordination of care. Family members, Health Care Practitioners and Community Services organizations that may be involved in your care may also be contacted in order to coordinate your services. All of the information collected will be kept in confidence under the requirements of the Massachusetts General Laws. In order to provide you with adequate and appropriate care, the following parties may have access to pertinent information about you:

- appropriate personnel/contractor from the ASAPs, Elder Affairs, or providers for the purpose of providing and managing your services;
- MassHealth if it is paying for some of your services; and
- those who may be involved in your care so they may understand your needs. The information will likely include your name, address, telephone number, emergency contact, other household members, health conditions, ability to complete daily tasks, extent of family help provided, and types of assistance needed.

This consent form does not cover the release of information on HIV status. A separate form must be used for the release of information on HIV status.

Your Rights: You have the right to:
- ask about where and how the information is kept;
- object to what information is collected and kept;
- see and copy (at your expense) the contents of your case file;
- ask that certain information not be released to other organizations; and
- ask that certain family members not be contacted.

I. Consent

Consent to Receive and Hold Information (check appropriate boxes)

[ ] I give my permission for the [ASAP] to share relevant information contained in my record for the purpose of coordinating my services with any of my Health Care Practitioners or Community Services organizations that may be involved in my care.

[ ] I give my permission for the ASAP to share my personal and/or health information with my family, caregiver(s) and/or other designated individual(s) as identified

below.

_____

_____

[ ] I do not give my permission for the ASAP to share my personal or health information with the following people or organizations as identified below.

_____

_____

Consent to Enrollment and Services

[ ] I am applying to [ASAP] for the services that are listed on the Initial Service Plan (the "Services"), completed today by me and the [ASAP] staff member who has signed this form.

The Services have been explained to me, and my questions have been answered. I understand that these Services will be reviewed by [ASAP] staff and may be modified if necessary. I understand my Care Manager will consult with me on any proposed changes.

I will share with the [ASAP] any community or health care related services I receive.

I understand that I may call [ASAP] if I have more questions. I understand that a staff member of [ASAP] will visit me again at required intervals to confirm that I am still eligible and that the Services are meeting my needs.

II. **Receiving Information**

I have received information regarding the topics checked below. I will call [ASAP] if I have any questions about this information.

[ ] My Rights and Responsibilities as an (ASAP) Consumer

[ ] Notice of Privacy Practices (HIPAA notice)

[ ] My Appeal Rights to the Aging Services Access Point

[ ] Public Emergency Health and Safety Information

[ ] Program and Service Information

[ ] Initial Service Plan – I have signed and received a copy of the Initial Service Plan, which was created with my participation.

[ ] Other Information: _____

III. Disclosure of Income Information (check appropriate boxes)

[ ] As a MassHealth waiver recipient, I will be required to provide information about my income; my spouse's income will be considered separately.

[ ] As a non-waiver MassHealth recipient, I will be required to provide information about my income, as well as my spouse's income if applicable, and will be responsible to pay a cost share as identified below, if the total income is over 300% of the Social Security Insurance Federal Benefit Rate (SSI FBR).

[ ] As a non MassHealth recipient, I will be required to provide information about my income, as well as my spouse's income if applicable, and will be responsible to pay a cost share as identified below.

[ ] I agree that I have given complete information about my income. This information is true and correct as far as I know. I agree that my total income and, if required, my spouse's total income equal (s) $_____. The payment I will be expected to make each month, if any, will not exceed $ _____ or _____%.
I understand my income information as well as my spouse's income if applicable will be collected when there are changes in my income, or on an annual basis.

I understand that my payment, if any, comes from cost-sharing schedules that are adjusted each year. **I understand that the rate may be changed by Elder Affairs, and that I will be given thirty days notice of any such change.**

[ ] I agree to make the payment monthly, or to tell [ASAP] if I cannot do so. I understand that if I do not make the required cost share my services may end. I understand I may be eligible for a cost share reduction if my expenses meet the necessary guidelines and that it is my responsibility to request a cost share reduction review by [ASAP].

[ ] I will provide additional information from another source/at a later date. I understand that the continuation of services depends upon my providing this income information and if I do not agree to the cost-share which is associated with my total income, including my spouse's income if applicable, those services may end.

IV. Signatures/Dates

To the Applicant: By signing this form, you allow the ASAP to share appropriate personal and health information about you.

Consumer	Date
Representative (identify relationship)	Date
Assessor and Title	Date