



**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: _____
PREFERRED 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)

Date