UPCAP
CARE MANAGEMENT PROGRAM
Consent & Authorization

I, _____, am voluntarily participating in the UPCAP Care Management/Federal Home and Community-Based Waiver Program. As such, I have been informed of my rights and obligations, and understand the purpose of the information I have or will provide to the program's Care Managers. I also understand that this information is private and confidential, true and accurate to the best of my knowledge. I further agree to notify UPCAP Care Management if my needs change or problems arise, such as hospitalization.

By my voluntary participation in Care Management, I agree to "Hold Harmless" UPCAP Care Management and its Care Managers from the errors and omissions of others.

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE, through my signature below, any Physician, medical practitioner, attorney, hospital, clinic, Social Security Administration, Department of Human Services, Public Health, Private Home Health Agency, Community Mental Health Agency, Banking institution, and/or other medical or medically related facility, insurance or reinsuring company having information available as to diagnosis, treatment, or prognosis, with respect to any physical or mental condition, treatment, and/or financial information, to give the UPCAP Care Management Program any and all such information. This information includes, but is not limited to, information related to medical condition, medications, treatment, financial plans, and/or service arrangements and plans. I also authorize UPCAP Care Management to share with any of the above noted entities information it has obtained from me, for the sole purpose of assisting me to remain in my home environment.

I UNDERSTAND that the information obtained by this authorization will be used by UPCAP Care Management to determine eligibility for benefits available through the Federal Home and Community-Based Waiver and/or other entitlement programs for which I may be eligible.

I FURTHER UNDERSTAND that any information shared by the UPCAP Care Management Program will be used by those agencies to better assist with the service provision of these agencies, and that such agencies and UPCAP Care Management will maintain such information in a confidential manner as prescribed by law.

I ACKNOWLEDGE that I have received a copy of this authorization and understand that the authorization will automatically expire one year from the date of my signature. I further acknowledge that I have received a Care Management Program explanation.

Signed this _____ day of _____, 20_____.

Name of Client: _____

Signature of Client _____

*** * * * * SPOUSE AUTHORIZATION * * * * ***

I authorize UPCAP Care Management to obtain information needed to determine eligibility required for the Federal Home and Community Based Waiver Program.

Signature of Spouse _____

INFORMATION REQUESTED

☐ SOCIAL SECURITY ADMINISTRATION: _____
☐ HOSPITAL MEDICAL RECORD (S): _____
☐ PHYSICIAN - DIAGNOSIS & H&P: _____
☐ INSURANCE INFORMATION: _____
☐ BANKING INSTITUTION: _____
☐ MDHHS: _____
☐ _____: _____

_____ _____
CM Signature Date

Please send to: UPCAP Care Management
(CONSENT)