GEORGIA DEPARTMENT OF COMMUNITY HEALTH

ELDERLY AND DISABLED WAIVER PROGRAM
Traditional/Enhanced
AUTHORIZATION FOR RELEASE OF INFORMATION
& INFORMED CONSENT

Client Name: _____ ID: _____

☐ 1. THIS IS TO CERTIFY THAT THE ELDERLY AND DISABLED WAIVER PROGRAM IS HEREBY AUTHORIZED TO RELEASE NECESSARY INFORMATION INCLUDING MEDICAL DATA TO THE AGENCIES WHICH WILL PROVIDE SERVICES TO ME AS OUTLINED IN THE TRADITIONAL/ENHANCED COMPREHENSIVE CARE PLAN.

***The level of care medical review team may request and/or retrieve additional medical information for the purpose of determining eligibility. Information may include hospitalization information, medical equipment needs, previous treatment, and medical history.**

☐ 2. This is to certify that I choose to participate in the Elderly and Disabled Waiver Program-Traditional/Enhanced Services and participation is based on annual renewal/approval of level of care.

☐ 3. This is to certify that I received information about the Consumer-Direction Option for Personal Support Services

☐ 4. This is to certify that I received educational/referral information about Abuse, Neglect and Exploitation.

☐ 5. This is to certify that I choose Nursing Home Placement.

☐ 6. Discharge plan / Emergency Preparedness plan discussed with client/representative.

☐ 7. This is to certify that I participated in the development of my Comprehensive Care Plan, including determining which services will be provided to me and which providers I choose through the Traditional/Enhanced Services.

☐ 8. This is to certify that I have been advised to contact my care coordinator with any service issues/problems.

☐ 9. I acknowledge the responsibility for the completion of the Elderly and Disabled Waiver Program-Traditional/Enhanced Medicaid application and submission of required documents to determine eligibility.

☐ 10. ALL OF THE MEDICAL, SOCIAL AND FINANCIAL INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

11. _____
SIGNATURE OF CLIENT OR CLIENT'S REPRESENTATIVE DATE

12. _____
SIGNATURE OF EDWP CARE COORDINATOR DATE