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James L. Kaufman, LCSW-R, *President and CEO*

Consent for Home and Community Based Services (HCBS)

Child's Name (Last, First, MI):			
Date of Birth:	Sex: ☐ Male ☐ Female	Medicaid CIN #:	Date of Appointment:

It has been explained to me that the child named has been referred for services and if eligible may receive one or more of the following Children and Family Treatment and Support Services:

- Community Habilitation
- Caregiver/Family Supports and Services
- Respite
- Prevocational Services
- Supported Employment
- Community Self-Advocacy Training and Supports

I have read and understand the Consent for Home and Community Based Services FAQ sheet. I understand how these services can help this child. I also understand that this child's health information may be shared with physicians, psychologists, school personnel or others who are members of the child's care team.

I know that I can change my mind and withdraw my consent for these services at any time.

By signing below, I authorize assessment and/or treatment for the child named above. I also authorize the sharing of information with members of the care team including; pediatrician, psychologist, service providers, hospital (if applicable) and school personnel directly involved with the well-being of the child. My signature confirms my understanding and consent to the Consent for Home and Community Based Services.

Medical Consenter name:	Medical Consenter Signature:	Date: