CONSENT FOR ASSESSMENT

I authorize_____to conduct an assessment and provide a referral for services for
(Provider Name)
_____.
(Service Recipient)

I agree to participate in the assessment and referral process to the best of my ability.

I understand that this consent will remain valid for a period of one (1) year, or until I withdraw my consent either verbally or in writing.

I understand that by signing this consent form, I am giving permission to the Arizona Health Care Cost Containment System (AHCCCS), all members of the Eligibility and Evaluations Department and my enrolled AHCCCS Health Plan, to access my information and records.

I understand that all the information gathered in the course of this assessment and referral process is confidential and may only be disclosed in accordance with state and federal law.

_____ (Initials) I want to be assessed and have a determination made about my eligibility for Serious Emotional Disturbance (SED) services.

_____ (Initials) I understand that I was previously determined eligible for Serious Emotional Disturbance (SED) services. I agree to a new Mental Health Assessment for the purpose of updating information and reengagement in SED services.

_____ (Initials) Applicant does not consent but is under court ordered treatment (COT) and is ordered to participate in the SED eligibility process. *Must include Court documents

_____ _____
Service Recipient (Signature) Date

_____
Legal Guardian (Print)

_____ _____
Legal Guardian (Signature) Date

_____ _____
Staff Member (Witness) Date

*Verbal consent (staff initials)- I attest the applicant provided verbal consent for the SED Evaluation

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Crisis Lines
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