





# Inventory for Client and Agency Planning (ICAP) Assessment Information and Consent

Please refer to the *Guidelines for the ICAP Process* for assistance in providing the required information

## Consent for Administration of the Inventory for Client and Agency Planning (ICAP)

Applicant/participant: \_\_\_\_\_

*Initial each line and sign below*

\_\_\_\_\_ My care coordinator has explained, and I understand the information provided in the *Guidelines for the ICAP Process*.

\_\_\_\_\_ I have received the *Guidelines for the ICAP Process*

\_\_\_\_\_ I understand that the responses provided by my ICAP Respondents must be accurate and will be used in assessing eligibility for a Medicaid waiver.

\_\_\_\_\_ I understand that the applicant listed above may or may not meet the eligibility criteria for a Medicaid waiver.

\_\_\_\_\_ I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

\_\_\_\_\_ I consent to a Senior and Disabilities Services representative conducting the ICAP assessment for the applicant/participant listed above.

\_\_\_\_\_  
Signature of applicant/participant or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of applicant/participant or Representative