State of Alaska • Department of Health and Social Service • Senior and Disabilities Services

Consent for Telehealth Assessment

Completion of this form will indicate your consent to participate in a telehealth assessment for the Medicaid Waiver or Personal Care Assistance (PCA) Program. For questions please contact the SDS Telehealth Coordinator at 907-269-3666 or 800-478-9996.

_____ _____
Recipient Name Today's Date

_____ _____
Telehealth Facility location Date and time of assessment

_____
Care Coordinator/PCA provider name and location

INTRODUCTION: Telehealth utilizes interactive video conferencing that enables an SDS Nurse Assessor at a distant location to conduct a required assessment of me for the Home and Community Based Medicaid Waiver and/PCA programs. I understand that this consultation will not be the same as a face to face assessment due to the fact that I will not be in the same location as my nurse assessor.

During the telehealth assessment:

- Details of my medical history including, but not limited to, medical reports, medication information, and critical incident reports will be discussed;
- A functional assessment in which I will be asked to demonstrate my ability to perform certain activities will take place;
- Non-medical personnel may be present to assist in operating video conferencing equipment; and
- Video, audio, and/or photo recordings will not be taken during the assessment.

Considerations: As with any assessment, there are considerations associated with the use of telehealth. These include, but may not be limited to:

- In certain cases, information may not be sufficient to allow for determination of eligibility for the Home and Community Based Medicaid Waiver or PCA;
- Delays in assessment may occur due to interruptions and/or failures of the equipment;
- At any time I may choose to stop the assessment and withdraw from the process; and
- Stopping the assessment and/or withdrawing from the process may cause additional delays.

Consent: If I have signed this consent agreement on behalf of a person who may be temporarily or permanently unable to authorize his or her own consent due to cognitive capacity, inability to sign, or a minor, I represent that I have the authority to sign this consent agreement on behalf of this person.

I have read and understand the information provided above regarding telehealth, have discussed it with my Care Coordinator or PCA agency representative, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my assessment.

I give permission for _____ to be present during my assessment.
example: friend, family member, escort

_____ _____ _____
Signature of recipient or authorized representative Relationship to recipient Date

If recipient signs with an X, or is unable to sign, provide a witness signature:

_____ _____
Signature of Witness Printed Name

Please fax copy to_____