ICAP Assessment Information & Consent

Mail to Senior & Disabilities Services, Developmental Disabilities, 3601 C St., Suite 310, Anchorage, AK 99503
or fax to (907) 269-3639

Applicant/Recipient

Legal Name:
Physical Address: New ☐ or Renewal ☐
City/State/Zip Code:
Mailing Address: MRDD ☐ or TEFRA ☐
Phone:
Residential Facility:
Agency:
School/Day Care Program: Medicaid #:

Care Coordinator

Name: CM #:
Telephone: Email:
Care Coordination Agency: CMG #:

☐ ***Legal Guardian*** ☐ ***Parent***
Name:
Daytime Telephone:

Current Medications ***Purpose***

(See page 4 of Guidelines for the ICAP Process for further)

Respondents (See page 4-5 of Guidelines for the ICAP Process for assistance in choosing appropriate respondents.)

Name: Daytime Telephone:
Relationship to client: If Translator/Accomodation Needed, Specify:

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Attachments (See Guidelines for the ICAP Process for required documentation. Check attached documents:

☐ Current Release of Information allowing for gathering of ICAP related information
☐ Supportive diagnostic documentation (If not attached, date of evaluation appointment:)
☐ Police reports/legal documentation
☐ Interdisciplinary Team Evaluation Report
☐ Current behavior management plan
☐ Other: (describe) _____

Comments/Other Pertinent Information:

Consent for ICAP Administration

Applicant Legal Name:

Initial each box and sign below:

☐ My care coordinator has explained, and I understand, the "Guidelines for the ICAP Process".

☐ I have received a copy of the "Guidelines for the ICAP Process" for my reference.

☐ I understand that the responses that respondents provide must be accurate and will be used in assessing eligibility for services.

☐ I understand that the applicant listed above may or may not meet the criteria for eligibility for services.

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

☐ I consent to having a Senior and Disabilities Services representative proceed with conducting the Inventory for Client and Agency Planning (ICAP) assessment for the applicant listed above.

Applicant or Legal Representative Signature	Date
Applicant or Legal Representative Printed Name	