

Consent for Assessment by Video/Teleconference

Purpose: This form asks for your permission to be part of a telehealth assessment with Senior and Disabilities Services (SDS). This meeting will help SDS to determine if your needs can be met through either an Alaskan Medicaid Waiver or Personal Care Services (PCS) program.

Introduction: Senior and Disabilities Services will be using video teleconferencing equipment to conduct your assessment over the internet. You will be in a private room at your local clinic with video and telephone equipment. This is called a “telehealth assessment”. An Assessor from SDS will connect to your clinic’s private telehealth system from a private room at their location. The telehealth assessment will be almost like a face to face assessment.

During the telehealth assessment:

1. The SDS Assessor will ask you about your medical history, reports from doctors about you, the medications you take and any major things that have happened to you in the previous year, like accidents or hospital stays.
2. The assessor will ask you to show how you do some simple tasks.
3. Other people may be with you in the room to make the video and telephone work correctly. You will be informed about who these people are.
4. Video, audio, and/or photo recordings will not be taken during the assessment.

Possible Risks: By signing this form, you are verifying to SDS that you understand the following:

1. We will protect your private information. Your private information may become available if the video & telephone or SDS processes do not work properly.
2. The information you give at the telehealth assessment may not be enough to decide your need for the services provided by the Medicaid Waiver or PCA program.
3. The telehealth assessment may take longer because of failures in the equipment or the signal.

Consent: If I am signing this agreement on behalf of a person who is temporarily or permanently unable to give their own consent due to cognitive capacity, physical inability to sign, or is a minor, I certify that I have the authority to sign this consent agreement on behalf of this person.

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

I give permission for _____ to be present during my assessment.

Signature of Recipient

Witness

Signature of Authorized Representative

Relationship to Patient

Date