LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Release of Confidentiality for Shared Personal Assistance Services (PAS) or Shared Long Term-Personal Care Services (LT-PCS)

Participant: _____

Date of Birth: _____ **Region:** _____

Support Coordinator Agency: _____

Service Type: ☐ **Adult Day Health Care (ADHC) Waiver LT-PCS**

☐ **Community Choice Waiver (CCW) PAS**

I am requesting that shared PAS or LT-PCS be included in my Plan of Care (POC) in order to participate in shared PAS or LT-PCS as indicated above.

I give permission for my name to be used in the POC, progress notes, individualized service plan, etc. of the other individual(s) I share supports with.

I understand that my permission to release this information may be canceled at any time, except when information has already been released.

_____ _____

Participant's Signature Date

_____ _____

Support Coordinator's Signature Date

_____ _____

Direct Service Provider's Signature Date

The following signatures are <u>only</u> needed if the participant signs with an "X".

_____ _____

Witness' Signature Date

_____ _____

Witness' Signature Date