



Family Mentor Project

Family Mentor Project Skilled Nursing Facility Consent Form

My relative/person receives services from (check one)

- Skilled Nursing Facility
- Hospital

Name of relative/person

I authorize Developmental Disabilities Community Services (DDCS – Formerly DDA) and Home and Community Services (HCS) Case Resource Managers and other Case Managers to share information about my relative/person with the Family Mentor Project staff.

I understand this involvement is voluntary and that I may stop my permission at any time.

Name (please print)	Date:
Signature	
Address: Phone: Email:	<input type="checkbox"/> parent <input type="checkbox"/> guardian <input type="checkbox"/> relative <input type="checkbox"/> other legal representative