Family Mentor Project

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Skilled Nursing Facility Consent Form

My relative/person receives services from (check one)

- ☐ Skilled Nursing Facility
- ☐ Hospital

Name of relative/person

I authorize DDA 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) Signature	Date:
Address: Phone: Email:	[ ] parent [ ] guardian [ ] relative [ ] other legal representative