NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

SED/SMI CONSENT

This form serves as consent to the evaluator working with the family to communicate determinations with the DHCFP/Medicaid and/or its designee (e.g., contracted Managed Care Organizations (MCOs) or fiscal agent), and, only if applicable, to Nevada Division of Mental Health and Developmental Services (MHDS) and/or the Nevada Division of Child and Family Services (DCFS).

SED CONSENT: (for children under the age of 18):

I hereby authorize _____ *(name of agency)* to: 1) Conduct an assessment for the sole purpose of determining whether my child has a severe emotional disturbance (SED) and; 2) Share the results of this assessment and determination only with the above named entities, and me. This Agency has explained fully, and to my satisfaction, the reasons as to why they believe my child requires an assessment at this time. All parties shall keep such assessment information strictly confidential.

_____ _____
Print Name of Recipient Medicaid ID Number

_____ _____ _____
Signature of Responsible Party Relationship to Child Date

_____ _____
Address Phone Number

SMI CONSENT: (for adults 18 years of age and older):

I hereby authorize _____ *(name of agency*) to: 1) Conduct an assessment for the sole purpose of determining whether I have a Serious Mental Illness (SMI) and; 2) Share the results of this assessment and determination only with the above named entities, and me. This Agency has explained fully, and to my satisfaction, the reasons as to why they believe I require an assessment at this time. All parties shall keep such assessment information strictly confidential.

_____ _____
Print Name of Recipient Medicaid ID Number

_____ _____ _____
Signature of Responsible Party Relationship to Recipient Date

_____ _____
Address Phone Number