



**CONSENT FOR ASSESSMENT**

I authorize \_\_\_\_\_ to conduct an assessment and provide a referral for services for  
(Provider Name)  
\_\_\_\_\_  
(Service Recipient)

I agree to participate in the assessment and referral process to the best of my ability.

I understand that this consent will remain valid so long as I am enrolled in my assigned Regional Behavioral Health Authority (RBHA), or until I withdraw consent.

I understand that by signing this consent form, I am giving permission to the Arizona Health Care Cost Containment System, all members of the Eligibility and Evaluations Department and the RBHA, to access my information and records.

I understand that all of the information gathered in the course of this assessment and referral process is confidential, and may only be disclosed in accordance with state and federal law.

I agree to participate in the assessment and to be referred for an appropriate level of services based upon the results of the assessment.

\_\_\_\_\_(Initials) I want to be assessed and have a determination made about my eligibility for Serious Mental Illness (SMI) services.

*I understand that if determined SMI, I will be enrolled in an integrated health plan, which provides comprehensive physical and behavioral health services. I understand that this could result in a change in my physical healthcare provider network*

\_\_\_\_\_(Initials) I do not want to be considered for Serious Mental Illness (SMI) services and would like a referral for General Mental Health (GMH) services only.

\_\_\_\_\_(Initials) I understand that I was previously determined eligible for Serious Mental Illness (SMI) services and this determination will be upheld. I agree to a new Mental Health Assessment for the purpose of updating information and reengagement in SMI services.

\_\_\_\_\_  
Service Recipient (Print)

\_\_\_\_\_  
Service Recipient (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Member (Witness)

\_\_\_\_\_  
Date

***\*Verbal Consent (Staff Initials)-I Attest the Applicant  
Provided Verbal Consent for the SMI Evaluation***

\_\_\_\_\_  
Date