Medication Consent Form

HOME AND COMMUNITY-BASED SERVICES

Participant Name:_____ **Plan Date:**_____

Legally Authorized Representative Name:_____

Prescribing Physician(s):_____

_____

_____

(Please list <u>all</u> prescribing authorities)

Consent Agreement: In accordance with Wyoming Statute 33-21-154, I hereby recognize that the individual(s) and/or provider organization(s) listed herein, and employees of the provider organization(s), are known as designated "friends". I hereby authorize these "friends" to assist the participant named on this form with medication and medical protocols during the following dates:_____to _____. *(Consent not valid over one year)*

Name of individual(s) or provider organization(s) who have permission to assist:

_____

Waiver providers that assist with medications must do so in accordance with the Division of Healthcare Financing's standards for medication assistance.

I agree that my providers can administer medications as trained. I have read and understand this authorization, dated _____.

_____

(Participant or Legally Authorized Representative Signature)