Government of the District of Columbia
Department of Human Services
Family Services Administration
Adult Protective Services Division

Consent to Protective Services and Release of Information Form

I, _____, hereby acknowledge and fully understand that the District of Columbia (District) Department of Human Services (DHS), Family Services Administration (FSA), Adult Protective Services Division (APS) investigates allegations of abuse, neglect, exploitation, and self-neglect of adults 18 years of age and older in the District (hereinafter referred to as "Adult"), who may be in need of protective services; and that the APS investigation conducted to determine if an Adult is in need of protective services may include the taking of photographs and/or the making of sketches (D.C. Official Code §§ 7-1901, *et seq.*).

I authorize representatives of APS to provide me with protective services, or to refer me to other persons or agencies for such services. These services include, but are not limited to:

- House cleaning
- Homemaker services
- Transportation services
- Temporary housing
- Representative Payee services
- Scheduling medical appointments (*e.g.*, dental, geriatric, podiatric, etc.)
- Arranging for food services
- Other services: _____

I authorize the release and/or disclosure of information to APS and APS's designated representative(s), for the purpose(s) of its investigation, including, but not limited to:

- Income verification documents (*e.g.*, documents from the Office of Personnel Management (OPM), Federal Retirement System, and Social Security Administration, etc.)
- Financial institution records (*e.g.*, bank statements)
- Housing and rental information
- Medical information (*e.g.*, Physician's name and contact information, prescribed medications, and diagnosed medical conditions, etc.)
- Medical insurance information (*e.g.*, Medicare, Medicaid, Private Insurance, etc.)
- Public benefits information (*e.g.,* Food Stamps, Social Security Income (SSI), etc.)
- Other: _____

I acknowledge that I am an Adult and I have read the provisions stated above, and/or an APS representative has verbally explained the provisions stated herein, and I understand and agree to the terms set forth in this Consent to Protective Services and Release of Information Form.

_____
Printed Name of Adult

_____
Address of Adult

_____ _____
Signature of Adult Date

_____
Printed Name of Witness

_____
Address of Witness

_____ _____
Signature of Witness Date

☐ Client Refused to Sign

THE UNAUTHORIZED DISCLOSURE OF HEALTH AND FINANCIAL INFORMATION RELATED TO THE PROVISION OF PROTECTIVE SERVICES VIOLATES THE ADULT PROTECTIVE SERVICES ACT OF 1984, AS AMENDED (D.C. OFFICIAL CODE §§ 7-1901, *ET SEQ.*; 29 DCMR §§ 2900, *ET SEQ.*).