Alabama Family Trust
ADMINISTERING SPECIAL NEEDS TRUSTS

CASE MANAGEMENT ASSESSMENT PARTICIPATION FORM

Beneficiary's Name: _____ Beneficiary's Date of Birth: _____

Alabama Family Trust Corporation ("AFT") desires to provide comprehensive case management assessment for its beneficiaries. Services offered under the Case Management Assessment Program can play an integral role in assisting beneficiaries with navigating complex eligibility rules for public benefits and in identifying other sources of assistance. **Case management assessments are offered without charge to AFT beneficiaries or their individual trusts. The Alabama Family Charitable Trust will pay for assessments for AFT beneficiaries who consent to case management assessment services through its case management assessment contractor.**

Please initial **only one** of the options below.

_____ As the beneficiary, guardian, agent under a power of attorney, or personal representative designated in the HIPAA form of the beneficiary named above, I agree to participate in the AFT Case Management Assessment Program. I understand that this agreement to participate includes the following:

- I consent to the beneficiary and beneficiary's family being contacted by the staff of the AFT Case Management Assessment contractor.
- I authorize AFT to share any necessary information regarding the beneficiary with the Case Management Assessment contractor.
- I understand that the Case Management Assessment Program is voluntary and that I may withdraw from the program at any time upon notification in writing to AFT.
- I understand that assessments may occur from time to time to assess the beneficiary's status and that this consent continues in effect until the beneficiary's death or written choice to withdraw from the program.
- I understand that I should retain a copy of this document for my records and that a photocopy of this form is as valid as the original.

_____ I do not have the appropriate legal documentation to consent to the beneficiary's participation in the Case Management Assessment Program, but I want the beneficiary to receive case management assessment services if possible. I request that AFT share any necessary information regarding the beneficiary with the Case Management Assessment contractor.

_____ As the beneficiary, guardian, agent under a power of attorney, or personal representative designated in the HIPAA form of the beneficiary named above, I choose NOT to participate in the AFT Case Management Program.

_____ _____
Signature of Beneficiary or Legal Representative | Relationship to Beneficiary

_____ _____
Printed Name | Date

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