COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Acknowledgment of Receipt of Verbal Consent

In response to COVID-19, individuals/entities are authorized to aid applicants for Medical Assistance upon receipt of verbal consent. ***The authorization of verbal consent will expire no later than the end of the COVID-19 Public Health Emergency.*** *This form is used to document an applicant's assignment of verbal consent to an individual/entity. This verbal consent is limited to the completion and submission of an application for Medical Assistance. This form should be used by individuals and entities such as Counties, Medical Assistance (MA) Sites, Presumptive Eligibility (PE) Sites, and Certified Application Assistance Sites (CAAS), also known as application assisters.*

Applicant Name:_____

Address:_____**Apartment Number:**_____

City:_____**State:**_____**Zip:**_____

Phone Number:_____**Date of Verbal Authorization:**_____

This form must be submitted along with the Application for Medical Assistance. **This form is required to complete the application process on behalf of the applicant.**

- If applying online at Colorado.gov/PEAK, upload and submit this verbal consent form with the application.
- If submitting a paper application to a Certified Medical Assistance Site, submit this consent form along with the paper application.
- Application Assisters must complete **Worksheet "A" Section "B",** this tells us about who is helping complete the paper application. Assisters using the online application should complete the section in PEAK to indicate they have helped complete the application.

The assister's signature on this form certifies the following:

(Assisters or caseworkers must read and inform the applicant of the following)

- You (the applicant) have been informed and understands my (the assister) role and responsibilities as an application assister.
- You (applicant) have granted me(assister) permission to create, collect, disclose, access, maintain, store, and/or use personal information in order to carry out the roles and responsibilities of an application assister as authorized by federal and state statutes and regulations.

- You (the applicant) understand this and grants me (the assister) the limited authority to complete, sign, and act on this application for Medical Assistance. *Additional written consent and authorization is required for appointment as your (the applicant's) limited authorized representative.*
- You (the applicant) understand this verbal consent authorizes (name of your organization) permission to release information to me (the assister)/and my organization.
- You (the applicant) understand this authorization can be revoked at any time.
- You (the applicant) will receive a copy of this consent form.

Your signature (typed or handwritten) certifies, under penalty of perjury, the information provided on this form and on the associated application is true and accurate to the best of your knowledge. You may be subject to penalties under federal law if you provide false and or untrue information.

Your Name:_____

Organization Name:_____

Assister's Signature: _____ **Date:** _____