

**IndependentChoices  
MEDIA CONSENT  
(OPTIONAL USE ONLY)**

Name of Participant: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ SS#: \_\_\_\_\_

Name of Representative (If Necessary): \_\_\_\_\_

IndependentChoices is not available to all persons in the United States. As a result of that, many people are interested in our experiences here in Arkansas. I understand that sharing my story is optional and does not affect my participation in IndependentChoices

- I am willing to share my story about my experiences with the IndependentChoices Program if contacted by DAAS.
  
- I am willing to be photographed.
- I am willing to do interviews for newspapers or magazine articles.
- I am willing to do an interview for a national or local television broadcast.
  
- I do not wish to share my experiences about the IndependentChoices Program.

\_\_\_\_\_  
Signature of Participant/Representative

\_\_\_\_\_  
Date

Complete this form, leave a copy with the participant and forward original to:  
Debby Ellis, PO Box 1437, Slot S530, Little Rock, AR 72203, FAX (501) 683-4180