LONG-TERM CARE OMBUDSMAN PROGRAM
REQUEST FOR STATE OMBUDSMAN AUTHORIZATION TO ACCESS RECORDS AND DISCLOSE INFORMATION

ODIN CASE #

PROGRAM NAME:	PSA #
LTCOP COORDINATOR NAME:	DATE OF REQUEST:

A. Resident Information

NAME:	PHONE:
FACILITY NAME:	
FACILITY ADDRESS:	

B. Resident Representative Information

NAME:	PHONE:

RELATIONSHIP TO RESIDENT *(Check all that apply)*

- ☐ Agent under Advance Health Care Directive
- ☐ Agent named in Power of Attorney
- ☐ Conservator
- ☐ Administrator of estate of resident
- ☐ Executor of estate of deceased resident
- ☐ Spouse or domestic partner, where there is no designated representative
- ☐ Adult children, where there is no spouse, domestic partner, or designated representative
- ☐ Other: Explain

C. Complaint *(Provide details of the circumstances – who, what, when, where, why, and how. Include information to be disclosed and the purpose of the disclosure.)*

D. Action Requiring State Ombudsman Authorization *(Check action/actions requiring authorization)*

☐ Access to resident records necessary to investigate complaint ***(Check type/types of records to access.)***

☐ Medical records ☐ Social records ☐ Financial records

☐ Disclosure of resident information to: ***(Provide name/names of agency and/or individual)***

E. Reason for State Ombudsman Authorization *(Check as each of the five elements is completed.)*

Ombudsman representative :

☐ Has determined that the resident is unable to provide informed consent ***(Check one below.)***

- ☐ a) Through direct observation
- ☐ b) Information provided by medical personnel not associated with a LTC facility

☐ Has reasonable cause to believe that the resident representative is not acting in the best interest of the resident, as detailed in Section C – Complaint; *and*

☐ Has reasonable cause to believe that the resident representative has taken action, inaction, or decision that may adversely affect the health, safety, welfare, or rights of the resident, as detailed in Section C – Complaint; *and*

☐ Has no evidence indicating that the resident would not wish the disclosure to be made; *and*

☐ Has reasonable cause to believe that it is in the best interest of the resident to make the disclosure.

F. State Ombudsman Authorization

- ☐ Yes
- ☐ No
- ☐ Comments

Joseph Rodrigues, State Ombudsman Date

G. Submission instructions

1. Upload completed OSLTCO S203 to ODIN as an attachment to the Case record.
2. Email stateomb@AGING.CA.GOV that you are submitting an OSLTCO S203 and provide the ODIN Case number as a reference. The State Ombudsman or his delegate will review the request and respond within two business days.

FOR OSLTCO USE ONLY

Date email received from local LTCOP		Initials of OSLTCO Staff person who received email	
Date email response sent to local LTCOP		Initials of OSLTCO Staff person sending response to local LTCOP	