Heart to Hand, Inc.
"A heart that cares with hands to help"

Revised: 4/19/21

Consent to Services Form

Name: _____ **DOB:** _____ **Date:** _____

Address: _____ **City, State and Zip:** _____

This consent allows staff to provide services within the approved standards of care in the Washington DC EMA and The State of Maryland including but not limited to the coordination of care and support services. This may include direct access and/or referrals to the following services:

Pharmaceutical Assistance, Medical Case Management, Non-medical Case Management, Oral Health Care, Outreach, Outpatient Ambulatory Medical Care, Early Intervention Services (Linkage to Care), Emergency Food Vouchers, Emergency Rental Assistance, Emergency Utilities Assistance, Psychosocial Support, Medical Nutrition Therapy, Medical Transportation, Mental Health Services, Substance Abuse Outpatient Care, Food Bank/Home Delivered Meals, Health Insurance Premium & Cost Sharing Assistance, Child Care, Linguistic Services, and any other services to which I may be entitled.

I agree to a required initial eligibility assessment as well as recertification **every 6 months** to determine continued eligibility for Ryan White funded services for as long as my case remains active. I understand the following will be checked at the time of recertification:

- Residency
- Proof of income
- Proof of insurance
- Emergency Contact

I understand that any changes to the above information within the 6-month period must be verified with documentation at the time of recertification. A recertification document must be signed by myself with or without changes to the above information.

I agree that if I fail to communicate with staff members about my care or otherwise fall out of H2H services without notice, that I may be contacted by a member of the Linkage to Care team to reengage in services. This may include a home visit or reaching out to my emergency contact, as required.

I understand that I can choose to stop receiving services at any time, for any reason, by notifying the case manager or appropriate staff of my desire to discontinue services. I understand that If I choose to discontinue services, it will not prevent me from receiving services that I am eligible for in the future. I may ask and expect that a case manager or appropriate staff complete a referral and facilitate case transfer to an agency of my choosing for continued services.

I, _____, have read and understand the consent guidelines provided above. I give consent to receive services from Heart to Hand, Inc. under the provided conditions, as required for my overall health and well-being.

_____ _____

Customer Printed Name **Customer Signature**

Medical Case Management Declination

- ☐ The customer does not have triggers that necessitate Medical Case Management at this time.
- ☐ The customer has stated that they will not participate in antiretroviral therapy (ART).
- ☐ The customer has declined to receive Medical Case Management services at Heart to Hand.
- ☐ The case manager has reviewed the importance of treatment adherence monitoring with the customer.
- ☐ The case manager has verified that the customer is receiving Medical Case Management from the following organization: _____

_____ _____

Customer Signature **Case Manager Signature**