Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

INFORMED CONSENT

This document is to verify that all Trillium Health Resources members have been provided Informed Consent as it related to receiving services in a group or congregate care setting.

Member Name: _____

Member DOB: _____

Legally Responsible Person (LRP) if applicable: _____

Provider Name: _____

Provider Location: _____

Applicable Service: Choose an item

Please check the appropriate boxes below.

- ☐ I have been informed that receiving services in a group setting increases my chance of contracting COVID-19 as it has been shown that community spread may occur in congregate care settings.
- ☐ I have been provided choices for alternative methods of service delivery including but not limited to individual services, telehealth services and/or telephonic services during this pandemic.
- ☐ After receiving the above information, I have chosen to receive my services face to face in a group setting.

_____ _____

Member or LRP Printed Name Member or LRP Signature

_____

Provider Signature and Credentials