Trinity Care, LLC

Mental Health Skill-Building Services

CONSENT TO SERVICES CONFORMATION

Individual:_____

Authorized Representative:_____

Please initial each section below.

___ I voluntarily consent to care and services provided by Trinity Care, LLC. and agree to participate in treatment decisions including development and review of individualized service plans.

___ I understand that if one of the Trinity Care, LLC. employees should exposed to blood or any body fluids of the individual or family member in a way that may transmit disease, my blood will be tested for infection with HIV, Hepatitis B an/or C viruses. A physician or other health care provider will tell me and the employee the result of the testing and provide counseling, if necessary.

For Medicaid Recipients Only:

___ I understand that I may appeal any decisions that affect my receipt of Medicaid covered services by notifying, in writing, the Appeals Division, Department of Medicaid Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219. This written request for an appeal must be filed within (30) days of this notification. If I file an appeal before the effective date of this action services may continue during the appeal process. However, if this decision is upheld by the Appeals Division, I will be required to reimburse the Medical Assistance Program for services provided after the effective date of this action.

___ I have been informed about similar service providers in the community and have elected to receive these services from Trinity Care, LLC

For all to sign:

I understand the contents of these forms and understand that it is in effect until/unless I rescind it is in writing and/or services are discontinued.

_____	_____
Individual	Date
_____	_____
Parent/Legal Guardian	Date
_____	_____
Trinity Care Staff	Date