Consent to Participate in Services

IDENTIFYING INFORMATION				
NAME	DOB		CASE #	GENDER
ADDRESS				

DATE

TREATMENT AND PARTICIPATION

I/ my ward/ my child agrees to participate in the services/treatment offered by LifeWays. The services may be provided by LifeWays or LifeWays' provider network. I understand that I will be asked to consent to a treatment plan based on my needs. My treatment plan (we also call this an Individual Plan of Service) will be written by my treatment team, and, if I want, will include input from my family, and/or other support professionals who take part in my care.

I understand that additional consents may be necessary for certain treatment options such as psychotropic medications

I understand that all services/treatments will be explained to my satisfaction including their purpose, risks, benefits, and any appropriate alternatives.

RECEIPT

The following items have been explained to me and I have received a copy of the following:

- Welcome to LifeWays Letter
- Your Rights Booklet
- LifeWays Guide To Services
- LifeWays Notice of Privacy Practices
- Information on Grievances, Appeals, and Second Opinions
- Michigan Advance Directive for Mental Health Care Brochure
- 2-1-1 Brochure
- LifeWays Community Mental Health Services Brochure
- Consumer Responsibilities

NOTIFICATION

I understand that LifeWays or LifeWays' Provider Network are required to coordinate my treatment with medical providers who care for my physical health, specifically my primary care provider.

I understand that when a LifeWays or LifeWays' Provider Network employee/provider has been accidentally exposed to my blood and/ or bodily fluids my/ my ward's/ my child's blood may be tested for Hepatitis B and HIV (Aids Virus). I will be told of any positive results unless I/ my ward/ my child cannot be found when the results are received. (in accordance with Michigan Law; PA 488 and LifeWays policy)

I understand that LifeWays or LifeWays' Provider Network is authorized to release non-identifying information on any reportable communicable disease, infection, and/or condition to the Michigan Department of Health and Human Services in accordance with the Michigan Mental Health Code Public Act 258 of 1974, Section 748, Rule 330.1748 Confidentiality.

FOLLOW-UP

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I understand LifeWays or LifeWays' Provider Network may contact me for purposes of obtaining follow up information concerning my satisfaction and progress since receiving services. This information is used internally for quality improvement purposes and to determine if services have been effective. All information is protected by LifeWays or LifeWays' Provider Network and its representatives to ensure confidentiality.

VALID

I understand that I may withdraw my consent and participation at any time without penalty.

I understand that I may revoke at any time except to the extent that action has been taken in reliance on it.

This consent shall no longer be valid one year from the date of this form. Any forms signed after the date on this form shall replace this form and be considered the most current consent.

Upon request, I may receive a copy of this consent

SIGNATURES

My signature acknowledges my understanding that I am agreeing to participate in services at LifeWays and/or one of LifeWays network provider agencies.

SIGNATURES

STAFF SIGNATURE / CREDENTIALS

DATE

CONSUMER / PARENT / GUARDIAN SIGNATURE

PRINTED NAME

DATE

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Note: A new consent form must be obtained if: legally competent minor reaches his/her 18th birthday; or c) change of guardianship status.

*Witness is responsible to, in good faith, assure that if the consumer signs, she/he was competent to give informed consent (R330.7003) (R300.6013) (a)-(c) Michigan Department of Community Health emergency rules, or if guardian signed, documentation is on file indicating that the court has empowered the guardian with the authority. If the witness does not feel the consumer is competent, refer to R330.6011 (3)-(4)

Testing for HBV/HIV without consent would not be for routine testing, rather for testing after unexpected staff contact with bodily fluid. 333.5133.10b “The HIV test is performed after a health professional, health facility employee, police officer, or fire fighter, or a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic licensed under section 20950 or 20952 sustains in the health facility, while treating the patient before transport to the health facility, or while transporting the patient to the health facility, a percutaneous, mucous membrane, or open wound exposure to the blood or other body fluids of the patient.”