

CONSENT TO PARTICIPATE

Respite Pilot Initiatives Evaluation

THE PURPOSE

Several of the respite programs like this one throughout the country are being evaluated by one of their funders, the Bureau of Primary Health Care. They would like to use the information we collect about you and the care you receive while you are here to help them improve respite programs like this one. Your name will not be connected to any of the information.

WHAT WE ASK OF YOU

If you agree to let them use the information about you, we will ask you to sign this form.

PRIVACY AND CONFIDENTIALITY

Your name will not be attached to any of the information we provide to the evaluators. They will have no way of knowing anything about you personally.

YOUR CHOICE

It is entirely up to you whether you want to have your information shared. It is VOLUNTARY. If you decide you do not want your information shared, it will not affect your relationship with this program or prevent you from receiving any of services you need.

RISK AND BENEFITS

We do not know of any risk to you for agreeing to let us share your information. Again, your name will not be attached to any information sent to the evaluators. If you agree, they will use the information to improve the services other people like you will receive.

SIGNATURE OF SUBJECT

BY SIGNING THIS FORM, I WILLINGLY AGREE TO LET THE PROGRAM USE MY INFORMATION FOR THIS EVALUATION.

Name of Subject

Signature of Subject

Date

SIGNATURE OF RESPITE COORDINATOR

I have explained the evaluation to the subject, and answered all of his/her questions. I believe that he/she understands the information described in this document and freely consents to participate.

Name of Respite Coordinator or Respite Staff

Signature of Respite Coordinator or Respite Staff

Date