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 | Date