

VANCOUVER BLACK THERAPY & ADVOCACY FOUNDATION

RECIPIENT INTAKE AND INFORMED CONSENT FOR PATIENT NAVIGATION SERVICES

Date:

Name:

Pronouns

Address:

Email address:

Telephone number(s):

Can messages be left at this phone number?

Emergency contact person:

Emergency contact number:

Are you reaching out on behalf of yourself, or someone else? If it is for someone else, please indicate their first and last name:

General questions

1. How did you hear about our program?
2. Were you referred to our program? If so, please indicate who referred you:
3. Do you have any accessibility requirements/needs?:
4. What task(s) would you like support with from our patient navigators? Please bold all that apply:
 - a. Housing support
 - b. PWD applications
 - c. Other applications (please specify): _____
 - d. Finding a therapist and/or healthcare provider
 - e. Getting connected with a therapist and/or healthcare provider
 - f. Accompaniment to appointments
 - g. Employment support
 - h. Food access support
 - i. Other (please specify): _____
5. Based on what you bolded above, please provide us with as much information as possible regarding the support you would like: _____

6. Do you anticipate any of the following barriers? If so, please bold which ones may apply so we can support you in creating a plan to navigate these potential barriers:

Transportation To and From Patient Navigation Meetings (if you plan to only need virtual support, skip to the next section)

- i. Public transportation needed
- ii. Private transportation needed
- iii. Other:

Communication/Cultural Needs

- iv. Primary language other than English
- v. Inability to read/write
- vi. Other:

The Vancouver Black Therapy & Advocacy Foundation (the "**Foundation**") agrees to and the recipient acknowledges and agrees that the Foundation will:

- Provide the patient navigation client with the patient navigation services that have been requested by the individual.
- Protect the recipient's privacy and personal information as described in the Foundation's Privacy Policy.
- Serve as an administrative liaison between recipients and service providers if necessary and as needed (collectively, the "services").
- Provide financial compensation for transportation of the client to/from in-person meetings up to \$20.
- Provide financial compensation for any food and/or drinks purchased for the client up to \$20 per meeting.

I, _____ (the "**recipient**")
acknowledge and agree to:

- Inform the Foundation if there are any changes or challenges in accessing patient navigation services.
- Inform the Foundation if I wish to change patient navigators at any time.
- Solely communicate with my patient navigator through email and Fongo, within agreed upon times.
- Respect the privacy, safety and boundaries of my patient navigator at all times.

I understand, acknowledge and consent to the Foundation's collection, use and disclosure of my personal information, including my name, contact information, and the date, time, attendance and cancellation status of all appointments to the extent required

by the Foundation for the purpose of administering the provision of the services and as required to confirm and verify the information required to pay for the services.

I understand, acknowledge and agree that my personal information collected, used and disclosed by the Foundation will be accessed by the Foundation's directors, officers, employees, agents and volunteers on a need-to-know basis and that the Foundation will ensure that all personal information will be encrypted and stored confidentially.

I understand and acknowledge that all patient navigation services are provided by volunteers and the Foundation is not responsible for any harm I suffer as a result of the patient navigators delivering the services, including their chosen methods, and I further acknowledge and agree that the Foundation is not responsible for the outcome of my patient navigation service.

I understand that I have the right to withdraw my consent at any time (by notifying the Foundation) and that I am under no obligation to attend or complete any or all of the patient navigation meetings offered and may change patient navigators at any time or discontinue services entirely.

I have read and understood these terms.

Signed this _____ day of _____, 20_____.

Signature of recipient:

Name of recipient (please print):

Vancouver Black Therapy & Advocacy
Foundation 303-1440 East Broadway,
V5N 5P2, Vancouver

hello@vancouverblacktherapyfoundation.com