



**CONSENT TO PARTICIPATE IN CHRISTIANACARE'S PROJECT IMPACT PROGRAM**

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By signing this form, I acknowledge that I have read, understand, and agree with the following terms of service, including all the relevant workflows and activities expressed here in this consent. I further acknowledge that I received, read, understand, and agree with the information about project impact, learning about Project Impact. I, \_\_\_\_\_, (parent/guardian of) \_\_\_\_\_, request and authorize ChristianaCare to sign us up to participate in the Project Impact (child's name) Program, and to share the time, date, location, and resources I need to participate in Project Impact support sessions.

**PROJECT IMPACT TERMINATION**

The program will automatically stop on the six months after the twelve-week program. Participants will be discharged from the program for the following reasons: Lack of participation, not completing homework, failure to practice reading and problem solving with the coach, and absence from sessions without prior notice or communication. I understand that the project committee will first attempt to contact me by the telephone number I provided to the program administrators when I signed up for the program before they terminate my participation. If they are unable to contact me by telephone, they will send my family a letter via US Postal Service mail. Families who have been terminated from the program due to the above reasons can re-apply for the program when they are ready to begin again; they will be required to go through the intake process again.

**RECORDING FOR EDUCATION AND FUTURE SESSIONS**

Project Impact coaches may choose to record the sessions for educating caregivers about the interventions used. Coaches may also use recordings for teaching purposes for staff, interns, and other families participating in the program. We will keep the recordings for two (2) years or less, after which we will securely destroy and dispose of the video and audio data. If a family agrees to allow Project Impact staff to record their parent-mediated intervention sessions, a separate consent form will be provided.

**RISKS**

I understand and agree that there is no guarantee of any specific outcome of health care services provided. Project Impact is an evidence-based program based upon parent-mediated intervention. Therefore, conditions at home and active participation are required for families to experience the maximum benefits of the program. Project Impact requires a significant amount of time spent in the sessions and completing weekly homework. Time spent on the program which cannot be recovered is one of the risks of participating in the program.

This program may be delivered via telehealth. There is currently minimal research that suggests evidence of the effectiveness of the program via telehealth. Providers are not certified in providing this intervention; however, they have experience in using interventions included in this modality. Additionally, there is a risk of accidental injury during sessions or playtime activities. Furthermore, like most healthcare expenses, the family may not be able to recover the money they spent on the program. The family may incur session co-pays or medical bills if the family does not have a medical insurance policy.

**FINANCIAL RESPONSIBILITY**

Sessions will be billed through medical insurance as family therapy, multi-family therapy, or individual therapy – the family may incur the cost of session co-pay, depending on their medical insurance policy. The family should check with their insurance provider to see how therapy sessions are covered and how often services can be provided, which may help the family decide upon the modality of services. The parent will also be expected to purchase a parent manual via hardcopy or PDF, which is available on Guilford Press or Amazon, prior to the start of treatment. The estimated cost is \$30.00. Please communicate with MAP if there is a financial burden, in which case MAP will support to problem solve.

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OTHER RESPONSIBILITIES	
<p>In addition to financial responsibility, the following responsibilities are important components to complete the program successfully:</p> <p><b>Participation.</b> One designated primary caregiver is required to participate in every session. Other family members and caregivers can attend sessions; however, the primary caregiver needs to participate in every session. The caregiver is required to practice skills, and complete readings and homework in between sessions, with the child.</p> <p><b>Technology needs.</b> Families need Zoom or another video conferencing technology with audio and visual components, to participate in the telehealth sessions. Participants need a valid email address and access to the internet.</p> <p><b>Environmental space.</b> While it is not required, we encourage families to set up a home environment that Project Impact coaches will allow for the most effective session.</p>	
PROGRAM COMPLETION	
<p>Project Impact coaches will present families and their children with a certificate of completion. It symbolizes a milestone and foundation for future treatments and therapy sessions.</p> <p>I certify that I have read the above statements, or they have been read to me, and I understand them. In addition, I have been offered the opportunity to ask questions, and my questions have been answered to my satisfaction.</p>	
Signature of Patient	Telephone Number
_____ Date / / Time	_____ Date / / Time
Signature of Legal Representative	Relationship to Patient
_____ Date / / Time	_____ Date / / Time
Doctor or Provider Signature	Doctor or Provider Print Name or ID#
_____ Date / / Time	_____ Date / / Time
Witness Signature	Witness Print Name
_____ Date / / Time	_____ Date / / Time
Telephone Consent:	
Name of person providing consent	Relationship to Patient if Decision Maker
_____ Date / / Time	_____ Date / / Time
Witness Signature	Witness Signature
_____ Date / / Time	_____ Date / / Time
<p><b>Interpretation:</b> The information has been presented to the: <input type="checkbox"/> patient <input type="checkbox"/> representative <input type="checkbox"/> decision maker in: _____ Language</p> <p>The person who provided the interpretation is a qualified medical interpreter.</p>	
Interpreter Name	Agency and ID# (if applicable)
_____ Date / / Time	_____ Date / / Time
Witness Signature	Print Name
_____ Date / / Time	_____ Date / / Time