

Consent to Services Form

Name: _____ **DOB:** _____ **Date:** _____

Address: _____ **City, State and Zip:** _____

I give consent to receive services from Heart to Hand, Inc. as necessary. I fully understand that this allows staff to provide services within the approved standards of care in the Washington DC EMA and The State of Maryland including but not limited to the coordination of care and support services. This may include direct access and/or referrals to the following services:

AIDS Pharmaceutical Assistance, Medical Case Management, Non-medical Case Management, Oral Health Care, Outpatient/Ambulatory Medical Care, Emergency Food Vouchers, Emergency Rental Assistance, Emergency Utilities Assistance, Medical Nutrition Therapy, Medical Transportation, Mental Health Services, Substance Abuse Outpatient Care, Early Intervention Services, Food Bank/Home Delivered Meals, Health Insurance Premium & Cost Sharing Assistance, Child Care, and Linguistic Services.

Print name of patient: _____

Signature of patient: _____