ARTAS Informed Consent Form
Linkage Case Manager

Agency Name: _____

The Georgia Department of Public Health HIV/AIDS Program would like to invite you to be part of the Anti-Retroviral Treatment and Access to Services (ARTAS) Intervention. ARTAS is an intervention funded through the Centers for Disease Control. The goal is to link people who are HIV-positive into HIV-medical care. Many people have problems getting into medical care. Some people never get HIV-medical care or stop receiving care at some point. ARTAS will help people with HIV connect with HIV-medical care. The following information can help you make a decision to work with ARTAS.

Description of Activities: These programs will help people with HIV connect to HIV-medical care. The goal of this program is to get people into HIV-medical care or if they have stopped receiving care, to get them reconnected with a health care provider. You would be enrolled in a program that is best for you. Once you enroll, ARTAS staff will contact you to help get you into medical care. The ARTAS Linkage Case Manager (ALCM) will help you address any issues you may need help with before getting medical care. In these cases, referrals for non-medical care such as housing, food assistance, child care, transportation may be made.

Linkage Case Management: The Linkage Case Manager works with HIV positive people to get them into medical care. A Linkage Case Manager can help people identify and solve problems that might keep them from getting into medical care and use community resources to help clients meet their goals of dealing with being HIV positive. Case management will continue for 3 months, or until the client enters medical care.

The Health Department tries to contact all people with HIV to make sure they know about their diagnosis, know where to get medical care, and help any partners get tested. This is required by law and would happen whether or not you are enrolled with this provider. So, if you are diagnosed with HIV or an STD, the Health Department may still contact you even if you choose not to participate.

Each program partner (agency/organization) will need to share information about patients. This informed consent allows the sharing of information between agencies for coordination of services and referrals to ensure you are getting all the care and services you need. You, the client, must consent for this information to be shared.

A separate consent form accompanying this document will also allow agencies to share information about whether you have made it to medical care and whether you are on medication to fight HIV. You have the **right to allow or to refuse** the sharing of this information. A separate consent form is signed at the time of each referral made.

ARTAS staff will keep in contact with you to make sure you get the medical care and supportive services you want and need. It is important that we have accurate and up to date contact information for you. You will be asked to provide contact information for alternative/emergency contacts in case you cannot be reached. If we cannot reach you and try to contact your alternative/emergency contact(s), **all of your personal health**

information will remain confidential and will not be shared with the alternative/emergency contact.

Data Collection and Confidentiality: All information collected will be kept confidential. Each program partner (agency/organization) collecting data will sign a confidentiality agreement before data collection can begin. Your personal information will not be published or shared. **When used for reports, information such as your name or address will NOT be part of the data. The results will NOT contain any personal information, such as name, date of birth, or address.**

Data Transmission: Data collected will be sent through a **secure database** to the Health Department to get information on the program(s) you are receiving. A secure database is one that has special protections and barriers that make sure the information is only seen by approved people. All data are stored in a protected system and no information such as your name or address will be reported outside of this system.

Benefits to Participation: You can benefit from ARTAS by getting help with receiving medical and other supportive services that can help you with being HIV positive. You may also receive referrals to other services that can assist you with maintaining a healthy and happy life as an HIV positive person.

Risk to Participant: You will be asked to discuss your HIV-status and any reasons why you are not getting medical care. If any questions make you feel uneasy, you do not have to answer those questions or discuss those topics. If you have any questions or concerns working with an ALCM, you can contact the Linkage Coordinator at the Georgia Department of Public Health (DPH) at 404-657-3100.

Alternatives to Participation: If you decide not to participate, your decision will not affect any of the services you may be getting now or may get in the future from any of the ARTAS partners/agencies/organizations.

Clients Right to Refuse to Participate or to Withdraw: Your participation is voluntary. You may choose to withdraw at any time. Your decision not to participate will in no way impact the services you may be getting now or may get in the future from any of the ARTAS Intervention partners/agencies/organizations.

Clients Right to Privacy: Your data will be shared with the Georgia Department of Public Health HIV/AIDS Program. However, your protected health information will be protected by standards set forth in the Health Insurance Portability and Accountability Act. Neither your name nor any personal information will be used in any published material. **All personal information such as name and address is removed prior to data analysis or for reporting purposes.**

Assurances/Signatures: You have discussed this program and had your questions answered. If you have any other questions at any time, you may contact the DPH Linkage Coordinator at 404-657-3100.

By signing this form, you show that you have read, agree, and understand the information in this consent form, and have been given a copy for your own records.

Printed Name of Client	Date	Printed Name of Witness	Date
Signature of Client	Date	Signature of Witness	Date
Signature of Reader	Date		

Reader Attests:
The client has informed me that she/he is unable to read. I hereby certify that I have read this consent form to the participant and have explained that by signing above, she/he agrees to participate.