Healthy Connections

HOME AGAIN PROGRAM

VIDEO CONFERENCING CONSENT FORM

Applicant Name: _____ Medicaid Number: _____

As part of my application for the Home Again program, my condition must be evaluated by the South Carolina Department of Health and Human Services (SCDHHS), the state agency that administers the Medicaid program in South Carolina. The Home Again Program will use video conferencing to complete the assessment process and assist with transition activities completed during the transition process.

I have been informed of the following risks with utilizing video conferencing:

1. Personal information, including but not limited to medical diagnoses and treatments, will be shared during the utilization of video conferencing for the assessment process.
2. It is possible that personal information may be overheard by others during the utilization of video conferencing.

☐ I agree and consent to utilizing video conferencing to complete the Home Again assessment process and for any transition activities required during the transition process.

I have access to _____ application to utilize for Video Conferencing.

☐ I do not consent to the use of video conferencing. I am aware that if I do not consent my Home Again case will be placed on the Home Again waiting list until face to face contact can be scheduled.

This Consent will expire two (2) years after my termination from the Home Again program.

_____ _____

Applicant's Signature Date

_____

If signed by responsible party, state relationship and authority to Sign

_____

Facility Witness (Social Worker or Discharge Planner)