

NEW YORK CITY DEPARTMENT OF HOMELESS SERVICES

SARS-CoV-2 (COVID-19) Testing Information Sheet and Consent

The New York City Department of Homeless Services (DHS) is collaborating with the NYC Department of Health and Mental Hygiene to detect if people have the SARS-COV-2 virus or COVID-19 infection. We are doing these tests to help limit the spread of COVID-19 during the pandemic.

If you sign this form and participate in testing, we will obtain three specimens (1 nasopharyngeal swab, 1 self collected nasal swab and 1 saliva) from you . We will also ask you a few related questions.

Who is being tested?

All shelter clients and staff will be tested.

Are there any benefits?

Yes, you will be able to know if you have the infection and watch for symptoms and seek care if needed. If you test positive, you will also be able to be isolated and lower the chance of spreading the COVID -19 virus to others or your loved ones.

Are there any risk?

The test is non-invasive and involves minimal risks. The nasopharyngeal swab may be slightly painful.

What about privacy?

Your information is protected by privacy laws. Your information will be kept confidential and secure, and will only be shared for purposes directly related to your COVID-19 testing such as measuring rates at each shelter, planning clients' isolation and general mitigation procedures. We may also share aggregate data about all testing, which will not individually identify you.

What are the costs?

The test will be done at no cost to you. Your insurance may be billed.

Is the COVID-19 testing voluntary?

This testing is voluntary. If you refuse to participate, you will still be able to use and receive all DHS services with no changes.

Whom to Call If You Have Questions?

If you have COVID-19 related questions please call 311.

Consent Statement

By signing below, I agree to have my specimens collected and for the diagnostic laboratory testing to be done.

I have read the above and have had my questions answered.

Print Participant Name: _____

Participant Signature: _____

Date: _____

Phone no: _____

CARES ID (for clients only): _____

Witness: Name _____ Signature _____

Thank you for agreeing for you to be part of this initiative.

TO BE COMPLETED BY PERSON COLLECTING THE SAMPLE

Name of the person collecting the sample: _____

Signature of the person collecting the sample: _____

Date: _____

Please provide a copy to the participant and keep the original for the record purposes.