

## **Attachment A.1: HPOG Informed Consent Form**

### **Health Profession Opportunity Grants (HPOG) Program Study Informed Consent Procedures and Form**

Programs often have their own informed consent or waiver forms to allow the organization or agency sponsoring the program to obtain data on the person from other agencies. The HPOG grantee programs' existing forms can be modified to also cover the participant's informed consent to be included in the federally-sponsored research on HPOG. Programs that do not currently have waiver or informed consent forms can use the standard HPOG form attached, appropriately modified to reflect their program terminology. The procedures and script that follow can be tailored as necessary to particular programs. The standard HPOG informed consent form appears after the script.

#### **Procedures for Obtaining Informed Consent**

Designated program staff will provide the client with a brief explanation of the HPOG Performance Reporting System and the other uses of the data. To make this explanation as clear as possible, the information that the staff person provides to clients is presented here in two ways. First, the major points that should be explained to clients are listed in bullet fashion; and second, there is a script to show how these points can be translated into a one-on-one discussion if necessary.

#### **Major Points to Be Covered**

The following are the points that program staff should explain to clients.

- ✓ We are trying some new ways to help individuals receive training and find employment in health care.
- ✓ Research is being conducted to see how well different approaches to training for health care jobs work. This program and research are funded by the U.S. Department of Health and Human Services, and they may fund other research on this program in the future.
- ✓ In this program, we collect some personal information from you, such as your name, date of birth, Social Security number, and your involvement in other programs. The researchers studying the program for the government also need this information.

- ✓ All the information collected for the program or for the research studies will be kept completely private, and no one's name will ever appear in any report or discussion of the evaluation results.
- ✓ The researchers are not evaluating you; they are evaluating the program. Research findings will be expressed for the program and as summary group statistics.
- ✓ Because of the study, researchers may contact some people in the future. You may refuse to answer any of their specific questions at any time.
- ✓ Researchers and program staff using the information collected must take all necessary actions to protect your information and they will pledge their agreement to protect privacy.

## **Suggested Standard Script for HPOG Programs to Use**

Program staff can discuss the points above with participants in the following way:

*This agency has received funding from the federal government for this special training program for health care jobs. Research studies are also being done to see how well the program works. The U.S. Department of Health and Human Services in Washington DC is funding this program and the research studies.*

*We are asking for your permission to let the researchers have information about you that they need to do their studies. You might consider some of the information personal (like name, date of birth, and Social Security number). The researchers need this to get information about your employment and services you get from other programs.*

*Giving permission to share your information will have no effect on the services, benefits, and supports you receive in this or any other program..*

*All of the information used in research will be kept private. Your name will never appear in any report or with any research findings. The researchers will combine the information about everyone in the program to analyze how the program helps people find and keep a job in health care. The research reports will write about the program as a whole—the researchers might say, for instance, that “80 percent of the participants enrolled in a training program at the community college;” or “two years after training 80 percent of the participants were still working in health care.”*

*We and any researchers who use your information must agree to have security measures in place to protect your privacy.*

*Researchers may contact you in the future to ask you some questions about how you are doing. We hope you'll decide to talk with them, but you may refuse to answer any of their questions at any time.*

*Do you have any questions?*

## **AGREEMENT TO TAKE PART IN THE HEALTH PROFESSION OPPORTUNITY GRANT PROGRAM AND STUDY**

This program is part of a new national project to train people for health care jobs. The program is funded by the U.S. Department of Health and Human Services in Washington, DC. That agency is also funding research to study how well our program works in helping people get training and jobs. Over the next several years, researchers will be using information about people in the program to do their studies. Researchers from Abt Associates and the Urban Institute are doing the current study. You are invited to take part in this important research.

The researchers need your permission to get information about you so they can understand the types of people in the program and how well the program is working. They want: 1) information about the training and services you get in the program; (2) information about you and your family, your education, and work history; and (3) personal data such as your Social Security number so they can get information about your employment, earnings, and public benefits like welfare.

Abt Associates and The Urban Institute will use data security procedures to keep all of the study data private and to protect your personal information. All of the information used in research will be kept private to the extent allowed by law. Your name will never appear in any report or with any research findings. The researchers will combine the information about everyone in the program to analyze how the program helps people find and keep a job in health care. Any forms or other papers that include your name will be kept in a locked storage area, and any computer files with your name will be locked and protected. Any researchers using information to study the program must follow all data security procedures and sign a privacy agreement.

Participating in the study is voluntary. You may withdraw your permission to share data at any time. Refusing or withdrawing permission later will not affect your eligibility for any services in this program or elsewhere. If you withdraw, researchers may continue to use information that was collected about you during the period you were in the study.

By participating in the study, you will help us, the federal government, and programs around the country learn about the best way to provide training and help participants get a health care job. You will be asked for information at certain times during your participation in the program and after you leave the program. You may be contacted by a researcher after you leave the program to answer some questions about your experiences. While we encourage you to answer their questions, you may refuse to answer them.

This agreement is effective from the date you sign it (shown below) until the end of the studies.

**Statement**

“I have read this form and agree to allow information about me to be used in the national Health Profession Opportunity Grant Program and Studies. I know that my participation in the research study is voluntary, that Abt Associates and the Urban Institute will use data security procedures to keep all of the study information private as described above, and that my name will never appear in any public report. I know that I can refuse to answer any questions researchers might ask me, and that I can stop being included in the research at any time without penalty. I understand that Abt Associates and the Urban Institute will get information about me, as described above.”

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PRINT NAME OF STUDY PARTICIPANT

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SIGNATURE OF STUDY PARTICIPANT

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DATE