Human Rights Clinic
ASSIST Network
Request for Services

Please read this before you meet with the client. The Human Rights Clinic (HRC) recognizes that HRC volunteers often observe client needs other than those satisfied through HRC's services. To address these needs, HRC provides volunteers with the opportunity to refer clients to additional services found within the client's community, especially with members of HRC's Access to Support and Services to Survivors of Torture (ASSIST) Network. Please read the instructions below and submit this form for each client.

Instructions

1. If your client displays symptoms and, in your professional opinion, has a need for medical, psychological or psychosocial services, please **advise the client** of this. **Please explain what these services are and what they will entail, so that the client understands what s/he is being encouraged to access. Ask the client if they would like help accessing services** to address this and other needs.

2. **Give the Community Resource Guide(s) to the client.** The guide lists resources for useful services in the client's community and is the client's to keep. Clients may use the guide **on their own** to access any services they consider useful. **Briefly review the guide with the client.**

3. **Inform the client** that the Community Resource Guide is designed the serve the needs of as many of HRC's clients as possible, so other resources may exist that are more culturally or linguistically appropriate or more convenient in regard to location or scheduling. HealthRight can try to help connect clients to services that may better meet their individual needs. In some cases, HealthRight can also help clients access pro bono psychotherapy or psychosocial support through partners in the ASSIST Network. **Ask the client if s/he would like HealthRight's help accessing resources.** If the client would like HealthRight's help, **please check which services the client would like HealthRight to help him/her access.**

4. **Ask the client whether s/he would like to receive personalized information about resources through his/her legal representative or if s/he is willing to be contacted by HealthRight to schedule a consultation with HealthRight staff.** Consultations either take place at the HealthRight office or over the phone (in NYC), elsewhere over the phone. Due to limited resources, not all clients who choose this option can receive an individual consultation; some will receive information through their legal representative.

5. **Please ask the client which services s/he intends to pursue <u>on her/his own</u> using the Community Resource Guide and mark these on this form.**

6. If the client reports already receiving medical, mental health or social services from another organization please **note the services the client is already receiving, the organization(s) providing them and the client's case worker**, if possible. HealthRight may be able to coordinate with the organization to ensure the client receives the services requested and to avoid duplication of services.

7. **Ask the client to sign the client consent** or this form will not be accepted. Please **ensure** the client reads the consent paragraph or is read the paragraph by the interpreter in a language the client understands.

8. Please **fax or scan and email the signed form** to Kate Macom at 212-226-6991 (fax) or Katherine.Macom@healthright.org. If you have questions, email or call Kate at 212-584-4842. Thank you for helping to connect your client to services in his/her community!

Human Rights Clinic ASSIST Network
Request for Services Form for Use by Evaluating Volunteers
CONFIDENTIAL

Date of Request: _____ Volunteer Clinician's Name: _____

Client Name: _____ DOB: _____ Gender: M F

Address: _____

Phone #: _____ Email: _____

Okay to call client at this number? Yes No Okay to leave a message? Yes No

May we speak with: ☐ Client only ☐ Someone else (List all: _____)

Country of Origin: _____ Ethnicity: _____ Date of arrival in US: _____

English proficiency: _____ Interpreter needed: Yes No Other language(s): _____

Attorney name and contact information: _____

Next hearing date and type (if known): _____

THIS CLIENT HAS REQUESTED HEALTHRIGHT'S ASSISTANCE IN ACCESSING:

☐ Medicaid (in New York only) ☐ Mental healthcare ☐ Housing ☐ Employment services (if work authorized)
☐ Food pantry/soup kitchen ☐ Medical care ☐ Clothing ☐ ESL/Adult Education

Please provide additional information, if necessary, **including symptoms**: _____

_____

Days/times client is available for services: _____

How far can client travel for services? _____

If recommending psychotherapy for client, therapist gender preference, if any: _____

Barriers to access (e.g. cost of travel, childcare, fear): _____

Check one: ☐ Provide information about resources through the client's legal representative.
☐ The client is willing to be contacted by HealthRight to arrange an appointment.

THIS CLIENT INTENDS TO PURSUE THE FOLLOWING FROM THE COMMUNITY RESOURCE GUIDE ON HIS/HER OWN, WITHOUT HEALTHRIGHT ASSISTANCE:

☐ Medicaid (in New York only) ☐ Mental healthcare ☐ Housing ☐ Employment services (if work authorized)
☐ Food pantry/soup kitchen ☐ Medical care ☐ Clothing ☐ ESL/Adult Education

THIS CLIENT IS ALREADY RECEIVING SERVICES:

☐ Medicaid (as available by state) ☐ Mental healthcare ☐ Food pantry/soup kitchen ☐ Housing
☐ Medical care ☐ Employment services ☐ Clothing ☐ ESL/Adult Education

Org(s) providing service(s):_____ Caseworker & contact information: _____

CLIENT CONSENT: I consent to participation in the ASSIST program. I understand that HealthRight will make efforts to find services but there is no guarantee that a suitable resource can or will be provided. I understand that HealthRight will not recommend a resource to me, but will only provide information about resources that are available in my community and that meet the criteria that I have provided. HealthRight does not screen or guarantee the quality of resources and I understand that I must determine for myself the quality of services. I understand that my participation in this process has no effect or bearing on my immigration proceeding. A copy of this form may be sent to my legal representative, who will be informed of any resources I am informed about or connected with. I consent that this form and any other documents provided to HealthRight may be shared with HealthRight's partner organizations in order to connect me to services. I consent that I may be contacted by a partner organization directly. I have read this paragraph and/or it has been read to me in a language that I understand.

_____ _____

Client Signature Date