

INFORMED CONSENT FOR PARTICIPATION IN WISCONSIN

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION - MFP

Completion of this form is voluntary. Failure to complete will mean that the individual cannot participate in the MFP demonstration.

NAME of Participant:	_____
MEDICAID ID Number:	_____ Birthdate: _____
Target Group	_____ Admission Date, if known _____
Facility Name / City	_____

Are you ready to move back home?

Wisconsin Home and Community-Based Services (HCBS) programs include a federal project that reimburses the state's long term care system for certain persons discharging from a facility to their own home or apartment or other eligible placement. As part of this project, we are required to provide survey information to the research agency so that it can be shown that people prefer to live in the community rather than in an institution.

Since you are interested in relocating to the community, we are asking that you consent to participate in this project if your community placement is eligible: Home, Apartment or Adult Family Home, 4 beds or less, or certain Residential Care Apartment Complexes (RCACs).

If you consent to participate, you will be interviewed just prior to discharge, again after about one year later and again after two years in the community. You can decline to be interviewed at any time, if you so choose. Your wish to not participate or to withdraw will not affect your placement in the community.

More information is provided to you on the back of this document.

SIGNATURE – Participant / Guardian (if applicable)

Date Signed

ACKNOWLEDGEMENT

I have read the informed consent materials to the applicant (or guardian) and I believe that he/she understands the MFP program information.

SIGNATURE – Agency Representative

Date Signed

Agency

Telephone Number

Email Address

COMPLAINTS

I understand that if I have any complaints or concerns about my participation in the MFP Demo, I can contact the MFP Project Director at:

DHS / Division of Long Term Care
MFP - Money Follows the Person, Room 418
PO Box 7851
Madison WI 53707
608-267-7131

Fax: 608-266-5629
MFP@wisconsin.gov

I have been informed that:

- The Money Follows the Person Rebalancing Demonstration MFP is sponsored by the federal Centers for Medicare and Medicaid (CMS). The demonstration will support states to rebalance their long-term support system, transition individuals from institutions, and improve the long-term care system overall.
- CMS has awarded a demonstration grant to the Wisconsin Department of Health Services (DHS) to operate MFP in Wisconsin.
- CMS has contracted with Mathematica Policy Research to evaluate MFP nationwide. Certain information about MFP participants will be shared with CMS and with Mathematica Policy Research in order to meet the statutory requirement to evaluate the project.
- Participation in MFP is completely voluntary. Refusal to participate in MFP will not affect eligibility for Medicaid or home and community- based services.

BENEFITS OF THE DEMONSTRATION

Potential benefits from my participation in the MFP Demo include the following:

- I will be offered services under the MFP Demo to enable me to transition from the institution in which I live to a home, apartment or small group living setting in the community. MFP Demo services will continue for one year as long as I continue to meet the eligibility requirements for the program.
- At the end of one year, I will continue to receive services under the home and community-based program available in my county as long as I continue to meet the eligibility requirements for the program.

PARTICIPATION IN RESEARCH AND POTENTIAL RISK

- Information about my participation in the MFP Demo will be provided to CMS and to Mathematica Policy Research, the evaluation contractor authorized by CMS.
- There is a slight risk that there would be unauthorized release of confidential information. The risk of unauthorized release of data is judged low because of the procedures in place to protect data and to limit its release to other parties (as described below).
- I may be asked to respond to surveys, participate in visits to my home or otherwise communicate with the evaluation contractor for the MFP Demo.
- I have been provided the opportunity to read material describing the research component of the MFP Demo. This material describes the basic goals of the research, the types of data that will be collected, how the confidentiality of the data is protected, the likely benefits and risks associated with the research, and who I can contact if I have any questions about the research material.

CONFIDENTIALITY

I have been informed that the information provided by DHS to CMS and the evaluation contractor is confidential and will be protected under HIPAA, Health Insurance Portability and Accountability Act.

EMERGENCY CONTACT INFORMATION

I will be provided with written information on the steps to take in the event of a non-medical emergency related to my care (i.e., worker does not show up, equipment failure).

WITHDRAWAL FROM THE PROJECT

My participation in the MFP Demo is entirely voluntary. If I enroll in the MFP Demo, I may withdraw at any time by completing a withdrawal form, available from my care manager or service coordinator or from the MFP Project Director.

I understand that if I lose Medicaid eligibility or decide to move to a residence that is not a qualified residence, I will no longer be able to participate in this initiative.

<input type="checkbox"/> I formally decline to participate in MFP	<input type="checkbox"/> I withdraw from participation in MFP
_____ SIGNATURE –Participant or Guardian	_____ Date Signed