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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-20941 (09/2018) | | |  | | | | | | | **STATE OF WISCONSIN** | |
|  | | | | | | | | | | | |
| **INFORMED CONSENT**  **FOR PARTICIPATION IN WISCONSIN’S**  **MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION** | | | | | | | | | | | |
| Money Follows the Person (MFP) is a federal demonstration that values and provides support for home and community based living. MFP reimburses the State’s long term care system when individuals move from long term, institutional placements to community integrated settings such as homes, apartments, adult family homes of four beds or less, and certain Residential Care Apartments. The project reimbursements support increased home and community based services for persons residing in institutions. | | | | | | | | | | | |
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| To include you in the MFP demonstration, your consent is necessary. Participation is voluntary. Choosing not to participate will not affect your discharge and transition to the community. If you decline to participate, your transition from facility to community will not be counted under the MFP demonstration. | | | | | | | | | | | |
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| More details on MFP demonstration can be found on the back of this document and at <https://www.dhs.wisconsin.gov/mfp/index.htm>. | | | | | | | | | | | |
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| **PARTICIPANT ACKNOWLEDGEMENT** | | | | | | | | | | | |
| Participant Name (Print) | | | Date of Birth | | | | | | Medicaid ID Number | | |
|  | | |  | | | | | |  | | |
| Facility Name | | Facility City | Facility Phone Number | | | | Admission Date | | | | Target Group |
|  | |  |  | | | |  | | | |  |
| I provide my voluntary consent to participate in Money Follows the Person. | | | | | | | | | | | |
| I decline participation in Money Follows the Person. | | | | | | | | | | | |
|  |  | | | | |  | |  | | | |
|  | SIGNATURE (Participant or Guardian if applicable) | | | | |  | | Date Signed | | | |
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| **AGENCY REPRESENTATIVE ACKNOWLEDGEMENT** | | | | | | | | | | | |
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| I have shared information about the MFP demonstration to the applicant (or guardian) and believe that he/she understands the program information. | | | | | | | | | | | |
|  |  | | | | |  | |  | | | |
|  | SIGNATURE of Agency Representative | | | | |  | | Date Signed | | | |
|  |  | | |  |  | | | | | | |
|  | NAME of Agency Representative (Print) | | |  | NAME of Agency | | | | | | |
|  |  | | | | |  |  | | | | |
|  | Email Address | | | | |  | Telephone Number | | | | |
| **SEND FORM BY FAX TO 608-221-6594** | | | | | | | | | | | |

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| I have been informed that:   * The Money Follows the Person (MFP) Demonstration is sponsored by the Federal Centers for Medicare and Medicaid (CMS). The demonstration supports states to improve and rebalance their long term support systems by transitioning individuals from institutions. * CMS awarded a demonstration grant to the Wisconsin Department of Health Services (DHS) to operate MFP in Wisconsin. * Certain information about MFP participants is shared with CMS to meet statutory requirements 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. * There exists a list of participant advocacy agencies I can consult if I feel my rights have been infringed upon by an agency, provider, or other entity.   Benefits of the Demonstration:   * I will be offered services under the MFP Demonstration, enabling me to transition from the institution to a home, apartment, or small group living setting in the community. MFP services continue for one year following relocation as long as I meet eligibility requirements for the Demonstration. * 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 program eligibility.   Participation in Research and Potential Risk:   * Information about my participation in the MFP Demonstration will be provided to CMS and Mathematica Policy Research. * A slight risk exists of the unauthorized release of confidential information. The risk is judged low because of established procedures in place to protect data and limit its release to other parties (as described below).   Confidentiality   * I have been informed that information provided by DHS to CMS and the evaluation contractor is confidential and protected under the Health Insurance Portability and Accountability Act (HIPAA).   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 (e.g., worker does not show up, equipment failure).   Withdrawal from the MFP Project Demonstration   * I understand my participation in the MFP Demonstration is entirely voluntary. Following enrollment, 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 in the event I lose Medicaid eligibility or decide to move to a residence that is not an MFP qualified residence, I will no longer be able to participate in this initiative.   Complaints   * I understand that if I have any complaints or concerns about my participation in the MFP Demonstration, I can contact the MFP Project Director at:   Address: DHS / Division of Medicaid Services  MFP – Money Follows the Person  Room 527  PO Box 7851  Madison WI 53707-7851  Fax: (608) 221-6594 |