



Consent for Participation in the New York State Money Follows the Person Project

Money Follows the Person (MFP) is a federal demonstration that provides support for home and community-based living. MFP reimburses the State when individuals move from long term, institutional placements to integrated community settings such as homes and apartments. These reimbursements support increased quality and availability of services in the home and community for individuals who need them.

An important piece of the MFP program is making sure that individuals have the chance to express their opinions and feelings about the services they receive. MFP offers a survey that asks questions about a person's experiences in the nursing facility or other institutional setting, and in the community. The survey, called the Quality of Life survey (QOL), is asked twice: once while the person still lives in the facility or institution and once about 11 months after he or she moves to the community. The survey is voluntary and you may choose not to be asked these questions.

Some Things You Should Know

- Participation is voluntary.
- Choosing not to participate or choosing to end your participation will not affect your discharge and transition to the community — it means only that your transition from facility to community will not be counted under the MFP demonstration.
- If you do not join the demonstration, you can still receive services in the community as long as you meet eligibility requirements for those services.

Who Can Participate?

- Individuals who have been living for more than 90 continuous days in a nursing facility, hospital or Intermediate Care Facility/IID and who are moving to a qualified community residence.*
- A qualified community residence is:
 - a home owned or rented by an individual or his/her family;
 - a residence in the community in which no more than four unrelated individuals live;
 - an apartment with an individual lease, with lockable access and egress, which includes living, sleeping, bathing and cooking areas over which the individual or his/her family has control.
- Individuals who have Medicaid at least one day prior to moving.*

*Individuals who are currently in nursing facilities and are interested in moving to the community may still receive the services of a Transition Specialist or Peer if they do not currently have Medicaid or have not yet been in a nursing facility, hospital or Intermediate Care Facility/IID for 90 days.

Participation in the Program

- You will be offered the services of a Transition Specialist, who will meet with you to talk about moving back to the community. The Transition Specialist will **help support you before, during, and after** your move.
- You will be offered the opportunity to meet with a peer, who is an individual with similar health concerns and experience, living independently in the community. Members of your family may also choose to speak with a family peer (a family member of an individual who has transitioned from institutional to community living).
- The Transition Specialist will ask you some questions, called a Quality of Life survey, before you move and about one year after you are back in the community. The survey is an opportunity for you to express your opinions about the services you receive and provides valuable information to the Department of Health to help improve the services. The survey is voluntary — you don't have to answer questions if you don't want to. All answers will be kept confidential.
- Although the demonstration period will end after 365 days of enrollment in MFP, your community services will not be affected. In other words, you will continue to receive the same community services as long as you continue to meet the eligibility requirements for those services.

Complaints

Contact the MFP Demonstration Project at One Commerce Plaza, 99 Washington Ave, Albany, New York 12210; by email at MFP@health.ny.gov; or by telephone at 518-486-6562.

Disclosure of Health Information

I understand that health care providers and other people involved in my care, such as the local Regional Resource Development Center (RRDC), the New York Association on Independent Living and its subcontractors (the local Independent Living Centers), the nursing facility where I am residing, and my Managed Care Organization, and Health Home and Care Management Agency need to be able to talk to each other about my care and share my health information with each other to:

- plan for my care;
- give me better care; and
- ensure that I can live safely in the community.

If I agree to participate in the MFP Demonstration project, I agree that my health information will be released and shared between the New York Association on Independent Living and its subcontractors, the Regional Resource Development Center, the nursing facility where I am residing, and my Managed Care Organization, and Health Home and Care Management Agency. This includes the sharing of all my health information, written or oral, **for the purpose of transition from, or preventing my re-placement in, a nursing home or long-term care facility.**

I authorize the release of information related to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION. I understand that, with some exceptions, health information once disclosed may be redisclosed by the recipient. I understand that the recipient is prohibited from redisclosing HIV/AIDS related, alcohol or drug treatment, or mental health treatment information or using the disclosed information for any other purpose without my authorization

Name: _____ Target Population: _____ Medicaid CIN#: _____

unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the RRDC, the New York Association on Independent Living and/or the local Independent Living Center. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. This authorization will expire three years after institutional discharge if I take no action.

Consent to Participate

I understand that participation in the MFP demonstration is my choice.

_____ Yes, I agree to participate in the MFP Demonstration Project

_____ No, I do not want to participate in the MFP Demonstration Project at this time

Signature of Individual

Date

OR

Signature of Designated Representative
(Parent, Guardian, Advocate etc., if needed)

Date

AND

Person responsible for submitting this document to the MFP Demonstration:

Name

Title

Date

Completed by Transition Specialist or Care Manager

Estimated Date of Discharge (if known):

Name of Institution & Location: