

Name: \_\_\_\_\_ Target Population: \_\_\_\_\_ Medicaid #: \_\_\_\_\_



## **Informed Consent for Participation in the New York State Money Follows the Person Demonstration Project**

### **General Information**

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 community integrated settings such as homes and apartments.

As MFP is a federal demonstration, learning about your experience and whether community living is preferred over living in an institution, is a vital component for evaluation of the project. Three surveys are conducted with you to gather this information. You may decline to be interviewed at any time.

### **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.
- If you do not join the demonstration, you can still receive waiver services as long as you meet eligibility requirements.

### **Who is Eligible to Participate?**

- Individuals who have been living for more than 90 consecutive days in a nursing facility, hospital or Intermediate Care Facility/IID (excluding Medicare covered rehabilitative care that is expected to be short-term in nature) and who are moving to a qualified community residence.
- A qualified community residence is:
  - a residence owned or leased 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, and which includes living, sleeping, bathing and cooking areas over which the individual or his/her family has control.
- Individuals must have received Medicaid inpatient services for at least one day prior to moving.

### **Participation in the Program**

Name: \_\_\_\_\_ Target Population: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

- Mathematica Policy Research has been hired to evaluate the project. New York State will provide service and health/wellness information about you to Mathematica, as part of this evaluation. Any information Mathematica collects about you will be confidential and used only for evaluating this project.
- The demonstration period will end 366 days after your enrollment in an HCBS waiver. One year following the end of the demonstration period, you will be contacted to voluntarily complete the final survey. You will be able to stay in an HCBS waiver and State Plan services as long as you continue to meet the required eligibility requirements.

### **Your Responsibilities**

By agreeing to participate in the demonstration you will agree to:

- Participate in the development of your service plan
- Be available to meet with a transition coordinator and case manager
- Be available to meet and communicate with representatives from the MFP program for up to two years after moving from the institutional setting
- Notify your HCBS waiver program representatives if you move during the follow-up period

### **Complaints**

Contact the MFP Demonstration Project, One Commerce Plaza, 99 Washington Ave, Albany, New York 12210 or by email to [MFP@health.state.ny.us](mailto:MFP@health.state.ny.us) or by telephone at 518-486-6562.

### **Consent to Participate**

I understand that health care providers and other people involved in my care, such as the local Regional Resource Developmental Center (RRDC), the New York Association on Independent Living and its subcontractors, and my Managed Care Organization 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
- to 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, viewed, and shared between the New York Association on Independent Living, the Regional Resource Development Center, subcontractors of the New York Association on Independent Living listed beginning on page 4 of this form, and my Managed Care Organization.

I agree that my entire Medical Record, which shall include all health information, whether written or oral, shall be shared. I agree to share any health information needed in order to transition from, or prevent my placement to, 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/AIDSRELATED 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

Name: \_\_\_\_\_ Target Population: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

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 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 its listed subcontractors. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. This authorization will expire three years after institutional discharge.

I understand the information provided above and that enrollment in the MFP Demonstration is my choice. I also understand that I may be asked to participate in a Quality of Life Survey after I have enrolled in the program. All items on this form have been completed, my questions about this form have been answered, and I have been provided a copy of the form.

\_\_\_\_\_ I agree to participate in the MFP Demonstration Project

\_\_\_\_\_ I do not want to enroll 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 \_\_\_\_\_

**For Official Use Only (Completed by Transition Specialist or Care Manager)**

Estimated Date of Discharge:	Name of Institution & Location:
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<b>Regions</b>	<b>Regional Lead Contact Information</b>	<b>Auxiliary Independent Living Centers</b>
<p><b>Albany North</b> Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, Washington</p>	<p>Southern Adirondack Independent Living Center (SAIL) 71 Glenwood Ave Queensbury, NY 12804 Tel: 518-792- 3537 Fax: 518-792-0979</p>	<p><u>North Country Center for Independence</u>, Plattsburg Tel: 518-563-9058</p>
<p><b>Albany South</b> Albany, Columbia, Greene, Rensselaer, Schenectady, Schoharie</p>	<p>Independent Living Center of the Hudson Valley (ILCHV) 15-17 Third Street, Troy, NY 12180 Tel: 518-274-0701 Fax: 518-274-7944</p>	<p><u>Capital District Center for Independence</u>, Albany Tel: 518-459-6422</p>
<p><b>Buffalo</b> Cattaraugus, Chautauqua, Erie, Niagara, Orleans, Wyoming</p>	<p>Western New York Independent Living (WNYIL) 3108 Main Street Buffalo, NY 14214 Tel: 716-836-0822 Fax: 716-835-3967</p>	<p><u>Southwestern Independent Living Center</u>, Jamestown Tel: 716-661-3010 Batavia WNYIL – Tel: 585-815-8501</p>
<p><b>Long Island</b> Nassau, Suffolk</p>	<p>Suffolk Independent Living Organization (SILO) 755 Waverly Avenue Holtsville, New York 11742 Tel: (631) 880-7929 Fax: (631) 946-6377</p>	
<p><b>Lower Hudson Valley</b> Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester</p>	<p>Putnam Independent Living Services (PILS) <i>A Satellite Office of Westchester Independent Living Center, Inc.</i> 1441 Route 22; Suite 240 Brewster NY 10509 Tel: 845-228-7457 Fax: 845-228-7460</p>	<p><u>Resource Center for Independent Living</u>, Kingston – Tel: 845-331-0541 <u>Rockland Independent Living Center</u>, New City – Tel: 845-624-1366 <u>Taconic Resources for Independence</u>, Poughkeepsie Tel: 845-452-3913 <u>Westchester Disabled on the Move</u>, Yonkers Tel: 914-968-4717</p>

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<p><b>New York City</b> Bronx, Kings, New York, Queens, Richmond</p>	<p>Center for Independence of the Disabled in New York (CIDNY) 841 Broadway, Suite 301 New York, NY 10003 Tel: <a href="tel:212-674-2300">212-674-2300</a> Fax: <a href="tel:212-254-5953">212-254-5953</a></p>	<p><u>Brooklyn Center for Independence of the Disabled, Brooklyn</u> Tel: 718-998-3000 <u>Bronx Independent Living Services, Bronx</u> Tel: 718-515-2800</p>
<p><b>Rochester</b> Genesee, Livingston Monroe, Ontario, Seneca, Wayne, Yates</p>	<p>Center for Disability Rights (CDR) 497 State Street Rochester, NY 14608 Tel: 585-546-7510 Fax: 585-546-7542</p>	
<p><b>Southern Tier</b> Allegany, Broome, Cayuga, Chemung, Chenango Cortland, Delaware, Otsego, Schuyler, Steuben, Tioga, Tompkins</p>	<p>Southern Tier Independence Center (STIC) 135 East Frederick St. Binghamton, NY 13904 Tel: 607-724-2111 Fax: 607-772-3606</p>	<p><u>AIM Independent Living Center, Corning</u> Tel: 607-962-8225 <u>Access to Independence, Cortland</u> Tel: 607-753-7363 <u>Catskill Center for Independence, Oneonta</u> Tel: 607-432-8000</p>
<p><b>Syracuse</b> Madison, Onondaga Oswego, Herkimer, Lewis, Oneida, St. Lawrence, Jefferson</p>	<p>ARISE Independent Living Center 635 James Street Syracuse, NY 13203 Tel: 315-671-2948 Fax: 315-671-2977</p>	<p><u>Massena Independent Living Center, Massena</u> Tel: 315-764-9442 <u>Resource Center for Independent Living, Utica</u> Tel: 315-797-4642</p>