



## North Carolina Money Follows the Person Informed Consent Form

Name:	SS # (last 4 digits) XXX-XX-
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MFP is an important demonstration project that will assist NC individuals to move from institutions back into the community. To be eligible for the project you must meet the following requirements:

- resides in an institution for persons with intellectual and/or developmental disabilities (private or State-operated ICF-MR facility) or a nursing facility for a minimum of six months prior to transition to the community,
- be eligible for Medicaid one month prior to transition, and
- move into a qualified community residence. A qualified community residence is any one of the following:
  - A home owned or leased by the individual or the individual's family member;
  - An apartment with an individual lease, with lockable access and egress, and that includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; or
  - A residence in a community-based setting in which no more than four unrelated individuals reside

Participation in this project is voluntary, however, if you choose to participate you must:

- meet the eligibility requirements /criteria and enroll in a Community Alternatives Program (CAP) waiver or PACE.
- Participate in development of an independent living plan/plan of care that includes goals determined by you and others you have chosen to assist you with planning.
- work in partnership with others to achieve your goals in the manner and time agreed upon.
- participate in three surveys about your quality of life; 2 weeks prior to transition; 11 months into the community; 23 months into the community.

During the project you may receive demonstration services which include supports for community living such as one-time transition expenses.

Any information collected about you will be confidential and used only for evaluating the project. You may withdraw from participation in the MFP project at any time. Your case manager will have a withdrawal form for you to complete and sign.

Upon conclusion of 365 days in MFP project, you may continue with CAP waiver services as long as the level of care assessment conducted annually indicates a continued need. If you are re-institutionalized for more than 30 consecutive days, you will be reevaluated for continued MFP eligibility and have an updated Plan of Care. If after three incidences/occurrences of re-institutionalization of 30 consecutive days or longer, you will no longer be considered for reentry into the Money Follows the Person project. You may, however, request a waiver slot as a non-Money Follows the Person recipient; acceptance will be according to funding allocated for the waiver in the county in which you reside.

Right to appeal as per the CAP Waiver or PACE in which enrolled.

**Complaints:**

Contact: The Department of Health and Human Services Ombudsman Program was created to address inquiries and complaints that consumers and their legal/guardians have regarding services that Department of Health and Human Services oversees or administers. The Regional Long Term Care Ombudsmen program can also be accessed through the CARE-LINE and is available 24 hours a day/7 days a week, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY).

**Consent:**

My signature below indicates the following:

I received information about MFP project and my questions about the MFP project have been answered to my satisfaction;

I acknowledge my understanding of the MFP project; and

I accept to participate in the MFP project, if I am determined eligible.

<b>MFP Participant Acknowledgement</b>	
Printed Name:	
Participant Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone #:	
<b>Guardian/Legal representative Acknowledgement (if applicable)</b>	
Printed Name:	
Guardian/Legal Representative Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone #:	
<b>Agency Staff (Lead Agency, LME, MFP, etc.) Acknowledgement</b>	
I have read and explained this document to the applicant and believe that he/she (or the guardian/legal representative, if signed) understands this document.	
Printed Name:	
Agency:	
Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone #:	
<b>Witness Signature, if applicable (if X'd)</b>	
Printed Name:	
Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone #:	
<b>Translator Signature, if applicable</b>	
Printed Name:	
Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone #:	