Money Follows the Person

Pennsylvania Department of Public Welfare and Department of Aging
Office of Long Term Living

Informed Consent for participation in the
Money Follows the Person Rebalancing Initiative

Participants served by the Office of Long Term Living and their family representative, guardian or advocate, if applicable, will be given information on Pennsylvania's Money Follows the Person (MFP) Rebalancing Initiative. A nursing home transition coordinator will explain the MFP Rebalancing Initiative in detail and obtain informed consent. Information will include:

- An explanation of the purpose and benefits of the MFP Rebalancing Initiative.
- An understanding that participation is voluntary and that the participant may withdraw from the initiative at any time. Current services will not be affected by a decision to withdraw.
- In order to participate, I, the participant must:
  - Have resided in a nursing facility for 90 days or more;
  - Move to a residence that qualifies under the initiative.
  - Receive Medicaid services for one day prior to transition from the nursing facility.
  - Choose to participate.
- A qualified residence can be:
  - An individual home owned by me or my family.
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  - An apartment, including apartments available in HUD subsidized housing complexes or congregate housing complexes that accommodate elders and people with disabilities.
  - Licensed living arrangements that Pennsylvania Department of Aging (PDA) has determined meet the requirements for a "qualified residence".
- It has been determined that I, the participant meet the requirements to participate in the initiative. I understand that if I lose Medicaid eligibility or decide to move to a residence that is not a qualified residence as listed above, I will no longer be able to participate in the initiative. If I am no longer able to participate, the nursing home transition coordinator will assist me in identifying alternatives to continue my transition from the nursing facility and continue living in the community.
- I understand that I will receive the same services through the MFP Rebalancing Initiative that I would receive if I chose not enrolled in the initiative.
- I understand that I will be receiving home and community based waiver services or the LIFE program authorized by Office of Long Term Living, and will be enrolled into a home and community based waiver or the LIFE program on the first day of transition to the community. I also understand that I am guaranteed access to a waiver or LIFE program appropriate to my needs as long as I remain eligible for Medicaid and meet the waiver level of care requirements for that waiver or the LIFE program level of care requirements.

- Consenting to participate in the MFP Rebalancing Initiative does not guarantee services to return to the community. Members of my transition team will explore my desire to return to the community, determine the feasibility of the transition and help me access services and supports necessary to support my transition. If my needs cannot be met in the community at this time, I understand that I may pursue community options in the future.
- I understand that I will be asked to participate in Quality of Life surveys, which will be conducted by independent contractors hired by the Commonwealth of Pennsylvania.
- I understand that a national evaluation will be conducted of Pennsylvania's MFP Rebalancing Initiative. Researchers hired by the federal Centers for Medicare and Medicaid Services will be using data about Initiative participants, including my information. All information is confidential and will only be used in accordance with federal rules and regulations.

I have been fully informed about participation in the MFP Rebalancing Initiative. I have had the opportunity to ask questions and have all of my questions answered to my satisfaction. My signature, and/or the signature of my family representative, guardian or advocate, if applicable, indicates full consent to participate in the MFP Rebalancing Initiative.

_____
Printed Name of Participant

_____ _____
Signature of Participant Date

_____ _____
Signature of family representative, guardian, Date
advocate (indicate relationship) * if applicable *

Quality of Life Survey Referral Form

Name: _____ _____
First Last

Date of Birth_____

Last 4 digits of SS#_____

**Medicaid ID number _____

Facility Name: _____

Facility Address: _____

County Where Facility is Located: _____

Facility Contact (Name & phone #): _____

Transition Coordinator/Care Manager Name: _____

Transition Coordinator/Care Manager Phone # and e-mail _____

Proposed Placement in Community & Demographics (address & phone if available): _____

_____

Community Care/Case manager program and staff assigned, if known (contact information):
_____

Does the participant need assistance in expressing their opinion? Yes / No

Has the individual signed the consent form? Yes / No.

Is there a guardian and has the guardian signed the informed consent? Yes / No

Who else needs to be involved in survey? _____

Target date of transition: _____

Name of Independent Enrollment Broker_____

*****Please send completed forms to Mary Jones-Furlow*****
Temple University mjonesf@temple.edu or fax (215) 204-6336