Montana Money Follows the Person
Consent for Participation

Applicant Name	Social Security Number	Medicaid Number

The Montana Money Follows the Person (MFP) Demonstration Grant is sponsored by the United States Department of Health and Human Services, Centers for Medicare and Medicaid (CMS). CMS awarded an MFP grant to the Montana Department of Public Health and Human Services to operate this program in Montana. This program is designed to help Medicaid Members like yourself, move from a skilled nursing home or hospital to a home in the community.

This informed consent serves to ensure your understanding of this program as well as your rights and responsibilities.

As an applicant for participation in the MFP demonstration project, I understand that my signature means:

- I do not have to participate in the MFP program.
- If I don't participate in MFP, I can still get Medicaid home and community-based services, provided I meet eligibility criteria.
- I will choose a regional transition coordinator to help me plan for services and supports that may be needed to help me have a successful transition to the community.
- My participation in the MFP program will continue for one year (provided I continue to meet eligibility requirements).
- Waiver and/or state plan services will remain if I continue to meet eligibility requirements for those programs regardless as to my participation in MFP.
- The success of my transition to community living is largely contingent upon my health, willingness to participate in transition planning, and my ability to live safely in the community.
- I understand that I must meet all eligibility requirements listed below to participate in MFP.
    - I must have resided in a hospital or skilled nursing facility for sixty or more days.
    - One of those days must have been paid for by Medicaid.
    - I must choose to live in a qualified residence which is defined as:
        - A home that I or my family own.
        - A residence in a community-based setting in which no more than three other unrelated individuals live.
        - An apartment with an individual lease (which can be in an apartment building, assisted living facility, and/or public housing unit), lockable doors (entry/exit), and which includes living, sleeping, bathing, and cooking areas over which I or my family has control.

- I understand that some, but not all, Assisted Living Facilities will meet the requirements for a qualified residence.
    - If I move to an Assisted Living Facility that does not meet CMS settings requirements, I may be required to move to a new facility to maintain continued coverage through the Medicaid Waiver Program.
- I understand that I cannot be guaranteed staff availability and that this is a risk inherent to community living. For this reason, I understand that a back-up plan for those times when my caregiver is not available, is essential to my success.
- I have been informed that the information provided by Montana DPHHS to CMS is confidential and will be protected under the Health Insurance Portability and Accountability Act (HIPAA).
- I understand that I have a responsibility to inform my Regional Transition Coordinator how I am doing once I move. I also need to tell my coordinator of problems I am having with my services or if my health changes and I need additional assistance.
- I have the right to report any incidents of abuse such as getting hurt (abuse) or being neglected (not being cared for) or if someone is taking my money without my permission (financial exploitation).
- I understand that my Regional Transition Coordinator and case manager are required to report all instances of abuse, neglect, or exploitation.
- I may choose to withdraw my participation in the MFP program at any time by completing a withdrawal form which I can get from my Regional Transition Coordinator.
- Complaints and concerns about my participation in MFP can be directed to the MFP Project Director by calling 406-439-6870. I can also send an email to AStaudinger@mt.gov or I can send a letter to MFP Project Director, Senior and Long Term Care Division, PO Box 4210 Helena, MT 59604.
- The Regional Transition Coordinator has provided me with information regarding my rights as a Medicaid waiver participant and has provided me with information regarding the process to file a grievance or appeal.
- By signing this consent form, I am agreeing to participate in the MFP program and to accept all conditions for participation.
- I understand that I will be given a copy of this consent form to keep.

Applicant Name (Printed)	Applicant Signature	Signature Date
Legal Guardian Name (Printed)	Legal Guardian Signature	Signature Date
Regional Transition Coordinator Name (Printed)	Regional Transition Coordinator Signature	Signature Date