North Carolina Money Follows the Person Project

Application for Participation

September 2015 ed.

Required Information on MFP Applicant: If We Don't Have It, We Can't Process the Application			
Today's Date:		**Applicant's SSN:**	
MFP Applicant's Name (Last Name, First Name, MI):		**Date of Birth:**	**Sex:** ☐ M ☐ F
Medicaid Number:	**Medicare Number:**		
Facility Name and Address:			**Facility County:**
Facility Social Worker/Point of Contact	Name:	Phone:	Email (preferred) or Fax:
Date of Admission to this Facility:			
Complete Informed Consent (see attached)			

Helpful Information: Having this Information Will Keep the Process Moving as Quickly as Possible	
Type of Facility: ☐ Skilled Nursing Facility ☐ Intermediate Care Facility for People with Intellectual Disabilities	☐ Acute Care Hospital ☐ Psychiatric Residential Treatment Facility ☐ Other (list here):
Does a family member, guardian or other person assume primary decision-making authority for this applicant? Yes ☐ No ☐	If "Yes," select the relationship type: ☐ Family/Friend—no legal responsibility for applicant ☐ Family/Friend—Guardian ☐ Family/Friend—Power of Attorney ☐ Family/Friend-Legal Status Unknown ☐ Organizational Guardian
Name and Phone number of Primary Family Member or Other Point of Contact:	
Estimated Transition Date:	

Completing the Application		
Name of Person Completing/Assisting with Application:		
Organization Name (if applicable):		
Phone:	**Fax:**	**Email:**

Affiliation (check one):

- ☐ Self, no help
- ☐ Local Contact Agency
- ☐ Facility listed above
- ☐ MCO
- ☐ CAP DA Lead Agency
- ☐ Area Agency on Aging
- ☐ Other (please list):
- ☐ Family, Friend or Corporate Guardian
- ☐ Center for Independent Living
- ☐ Private Medicaid Provider
- ☐ DVR-IL
- ☐ Civic/Advocacy Group Not Otherwise Listed
- ☐ PACE

About Me: My Community-Based Living Support Needs and Interests

This section is voluntary, but will help us direct your application to the right transition team and make sure your application meets with Project requirements

Type of Housing do you prefer (check one):

- ☐ My own home/apartment
- ☐ My family's home/apartment
- ☐ Group home of four people or less (Individuals with Intellectual Disabilities only)
- ☐ Alternative Family Living/ "AFL" (Individuals with Intellectual Disabilities only)

Do you currently have a home outside the facility? Y ☐ N ☐	Do you need assistance with finding housing? Y ☐ N ☐

If you have housing, list home/apartment address:

County you prefer to live in (REQUIRED, no response may cause delay in processing):	

About Me: My Community-Based Living Support Needs and Interests

This section is voluntary, but will help us direct your application to the right transition team and make sure your application meets with Project requirements

When you move to the community, please list family, friends, and others from religious and civic groups that may be *willing to assist with hands-on care or backup support*. Civic groups may include Red Hat, Lion's Club, Rotary Club, book clubs, Sororities/Fraternities, etc.

Name:	Relationship/affiliation:	Phone Number, other means of contact:

About Me: My Community-Based Living Support Needs and Interests				
Activity (Please check boxes that apply)	**I Need A Lot of Support** (I use a wheelchair or need hands-on assistance, people to be nearby most of the time)	**I Need Some Support** (I may need some help with some of these tasks, but not all of them; I need support sometimes but not all of the time)	**I Don't Need Any Support—I can do it myself.**	**Notes**
Moving around				
Getting out of bed or chair				
Bathing, dressing, taking care my bathroom needs				
Daily decision making				

Who provided the information to complete this section? (Check One)

- ☐ MFP applicant directly (even if someone else needed to physically write)
- ☐ A family member, guardian or other support to the applicant
- ☐ Facility staff
- ☐ Other (list here):

Complete this form as well as the MFP Informed Consent Forms and fax all forms to 919-715-4159 or email (password protected) to mfpinfo@dhhs.nc.gov

MFP staff use only			
Date Completed Medicare Part A Rehab:	Medicaid county:	Facility Type Listed In NC FAST:	Income From NC FAST:
Meets qualified institution/facility	☐ Yes ☐ No	Meets qualified residence	☐Yes ☐No
In institution/facility at least 90 days	☐Yes ☐No	Medicaid eligible	☐Yes ☐No
Transition Coordination Agency			
Authorized By	*(Print name)*		
	(Signature)		*(Date)*

NC MFP Informed Consent and Authorization to Share Information

Hello!

We are so glad that the North Carolina Money Follows the Person Demonstration Project (NC MFP) may be able to assist you in returning to your home and community. Thank you for taking the time to read this information. We want to make sure you have a clear understanding of the NC MFP Project and its transition process. **We know there is a lot of information here, so please don't hesitate to ask questions and get assistance. We're happy to help.**

Thanks for Your Interest in NC MFP!
The NC MFP Staff
1-855-761-9030

To Complete this Form, Think "Inside the Box"

☑

Throughout this document there are places to check a box. By checking the box, you are showing that you have read and understand the material in that particular section of this Informed Consent Form.

Who Qualifies For NC MFP?

Money Follows the Person (MFP) is a demonstration project that assists individuals in North Carolina to move from qualified institutions back into their own communities. To be eligible for MFP, a person must:

- ▷ Currently reside in an institution for intellectual and/or developmental disabilities (private or state-operated ICF-IDD facility) or currently placed at a skilled nursing facility for three months or longer.
  - ▸ The eligibility timeframe may be impacted if facility services have been paid for with Medicare Part A funding.
- ▷ Be eligible for Medicaid prior to transitioning back into the community.
- ▷ Move into a qualified community residence which includes <u>one</u> the following
  - ▸ A home owned or leased by the individual or the individual's family member.

- An apartment with a monthly lease including lockable access along with living, sleeping, bathing, and cooking areas which the individual or their family have domain over.
- A residence in a community-based setting with no more than four unrelated individuals reside.

▷ Meet the eligibility requirements/criteria of the waiver or PACE program that s/he intends on using upon transition.

▷ **REALLY IMPORTANT: MFP approval doesn't automatically mean you have a waiver slot.** While MFP participants have priority status for MFP-reserved waiver slots, it's important to know that 1) there must still be MFP waiver slots available that waiver year AND 2) you must also meet the waiver-specific requirements before a waiver slot can assigned to you.

☐ **YES, I have read this section and understand what it means.**

Your Responsibilities In the Transition Process:

Important Information about Discharging from the Facility and MFP Enrollment:

It's important that you coordinate your discharge date with your MFP transition team. If you transition without having an approved MFP application and without MFP staff knowledge, **you may lose your MFP status**. This means you will not be eligible for MFP's "startup" funds or have priority status for CAP services.

☐ **YES, I understand that I may not be eligible for MFP services if I discharge without coordinating with MFP staff.**

The success of a transition relies on collaborative work by the participant, family, guardian, friends, community based programs, case manager, transition coordinator, and MFP staff.

▷ To the extent possible, the MFP participant will guide his/her own transition process and assume responsibilities in ensuring the transition occurs (i.e. calling possible housing options, identifying a bank, etc.)

▷ Along with their families as appropriate, MFP participants agree to help develop their Transition Plan, including goals designed to make community based living reasonable and accessible resources outlined.

▷ Along with their families as appropriate, work with the entities that are making community based living an option by achieving set goals within set time frames (like not cancelling meetings at the last minute, following up on my "to do list" as appropriate, returning calls promptly, etc.)

☐ **YES, I have read this Section and agree to do my part to make sure my transition is organized and well-planned.**

Transition Year Stability Resource Funding

- ▷ Depending on the community services you need, NC MFP participants may have access to up to $3,000.00 of "startup" funds to help cover the cost of the one-time expenses associated with transitioning that cannot be accommodated in the waiver budget.
- ▷ Examples include: pre-transition staff training, housing and utility deposits, deposits on personal emergency response systems, home modifications and household supplies.
- ▷ These funds are ONLY available up to 365 days AFTER you transition.
- ▷ Funding requests are submitted by the MCO, CAP or PACE Lead Agency and must be authorized by MFP staff.

☐ **YES, I have read this Section and understand the "basics" of the Transition Year Stability Resource Fund**

MFP Quality of Life Survey

- ▷ Each MFP participant can help ensure that NC and Medicaid have good data in order to improve the services needed by transitioning individuals by participating the Quality of Life survey effort.
- ▷ I understand that I will be asked to participate in a Quality of Life Survey three times: before I transition, about one year after I transition and two years after I transition.
- ▷ I understand that participation in this survey process is voluntary, confidential and will not impact my ability to transition.
- ▷ Participation in the survey will help MFP build services and supports that better support people to return to and remain in their own homes and communities.
- ▷ MFP staff or Quality of Life Surveyors designated by MFP staff will be contacting you to participate in these surveys.

☐ **YES, I have read this Section and understand I will be asked to participate in the MFP Quality of Life Survey three times: once before I transition and twice after I transition.**

Continuation of Care

Upon the 365th day of participating in the MFP Demonstration Project, you may continue with wavier services if you continue to meet the wavier program's level of care and other requirements.

☐ **YES, I understand that if my circumstances don't change, my services should continue after my MFP participation ends.**

Enrollment, Disenrollment and Re-enrollment

Reiterating Important Information about Discharging from the Facility and MFP Enrollment:

It's important that you coordinate your discharge and discharge date with your MFP transition team. If you transition without having an approved MFP application and without MFP staff knowledge, **you may lose your MFP status**. This means you will not be eligible for MFP's "startup" funds or have priority status for waiver services.

☐ **YES, I understand that I may not be eligible for MFP services if I discharge without coordinating with MFP staff.**

Important Information about Why a Participant May be Dis-enrolled Before Transitioning

NC MFP is going to work hard to help you get home. Our transition coordinators are passionate about what they do and want to support your transition. However, it's important to know that NC MFP may dis-enroll an MFP Participant from the Program prior to transitioning for the following reasons:

1. MFP participant does not meet the criteria for the applicable program (e.g. CAP DA, PACE, Innovations, etc.).
2. MFP participant is unable or unwilling to move into a "qualified residence" that is both authorized under federal law and supported by the applicable NC waiver program.
3. MFP participant does not honor transition-related commitments as outlined in the NC MFP Informed Consent document. Participant refuses to comply with agreements as outlined in the Informed Consent, Transition Plan of Care or Risk Mitigation agreements

NC MFP reserves the right to dis-enroll an MFP participant who has not yet transitioned at any time for the reasons outlined above. If after six months from the day of the first transition meeting, the transition coordinator determines that the participant does not yet meet the applicable waiver program requirements or have acceptable housing identified, the transition coordinator may also recommend disenrollment so long as the decision is supported by MFP leadership staff.

When MFP elects to dis-enroll an MFP participant, the participant has a right to appeal the decision and will receive guidance on doing so. Appeal rights for Innovations, CAP DA/CHOICE and PACE are managed according to the guidelines of the specific program.

REASONS WHY A PARTICIPANT MAY BE DISNROLLED AFTER TRANSITONING:

An MFP participant retains MFP participant status for one year after the participant's transition date. After 365 days, the participant is automatically dis-enrolled from the MFP Program. During this 365 day period, MFP participation can be terminated for the following reasons:

1. Participant no longer meets the criteria for the waiver program or PACE program;
2. Participant is re-institutionalized for more than 30 days;

3. Participant transitions to a residence that does not meet MFP federal criteria or does not meet applicable home and community-based program criteria;
4. Participant no longer receives Medicaid;
5. Participant refuses to comply with agreements as outlined in the Informed Consent, Transition Plan of Care or Risk Mitigation agreements; or
6. Participant no longer meets relevant level of care criteria.

☐ **Yes, I understand the reasons why NC MFP may dis-enroll me and that I would have the right to challenge that decision through the Medicaid program's appeals process.**

Important Information about MFP Re-Enrollment Once You Transition Into the Community:

Any MFP participant that is re-institutionalized for a period longer than 30 consecutive days will be considered **dis-enrolled** from the program. However the individual is eligible for re-enrollment without re-establishing the three month institutionalization requirements, as long as the individual meets Medicaid waiver eligibility criteria. The participant then will be eligible for MFP services at the enhanced Federal Medicaid Assistance Percentage match. Any participant having 3 incidences of re-institutionalization of 30 consecutive days or longer will not be considered for reentry into the MFP Project.

Any former participant may re-enroll after being re-evaluated and with an updated plan of care in place. Once the individual is found eligible for community based services the updated plan of care addressing any change in the status of the MFP participant and/or any concerns with lack of necessary community supports will be submitted to MFP staff for review. If a former participant reenters a qualified institution for 6 months or longer then the participant will be defined as a "new" MFP participant if they wish to consider transitioning again.

☐ **YES, I understand this Enrollment and Re-Enrollment Policy.**

Withdrawal

Since the MFP Demonstration Project is voluntary, a participant is able to withdraw at any point by making the request in writing to the Project at any time. MFP participants also have the right to appeal under the CAP wavier or PACE program, depending on which he/she is enrolled.

☐ **YES, I understand I can withdraw from the MFP Program at any time by letting the Project Staff know in writing.**

Complaints

MFP staff strives to be responsive to concerns and issues that you may have. We encourage you to contact us directly if you have concerns about the quality of service you are receiving. We may be able to help you resolve your concerns and encourage you to call our toll-free number at: 1-855-

761-9030. If we have not been able to resolve your concerns or you would prefer to not discuss your issue with MFP staff, the Department of Health and Human Services (DHHS) Ombudsman Program was created to address inquiries and complaints that consumers and their legal guardians have regarding services that DHHS oversees or administers. The Regional Long Term Care Ombudsman program can also be accessed through the CARE-LINE 24 hours a day, 7 days a week, by calling 1-800-662-7030 (English or Spanish) or 1-877-452-2514 (TTY).

☐ **YES, I understand the different ways to make a complaint about the services I receive through NC MFP.**

Giving my Consent

- ❑ By checking here and signing below, I am letting MFP staff know that I understand the information contained in this MFP Informed Consent document.
- ❑ By checking here and signing below, I am letting MFP staff know that I have asked any questions I have at this point and understand I may ask additional questions at any time.
- ❑ By checking here and signing below, I understand I can get a copy of this document any time I want one.
- ❑ By checking here and signing below, I understand that I can change my mind about these agreements at any time, but changing my mind may impact my ability to participate in the MFP Project.
- ❑ By checking here and signing below, this document is valid for one year after the date of my transition or earlier, if I decide to revoke it.

☐ **YES, I would like to become a North Carolina Money Follows the Person participant.**

SIGNATURES

_____ Name of MFP Applicant (please print)

_____Signature of MFP Applicant

_____Date

_____Signature of Guardian or Authorized Representative (if applicable)

_____Date

NC MFP Application: Authorization to Disclose Health Information

Please complete this document as part of your MFP Application

MFP Applicant Name _____

Date of Birth _____

MFP Applicant Medicaid Identification Number _____

To ensure a coordinated and organized transition to a new place of residence,

I _____ (MFP Applicant or Authorized Representative) hereby authorize NC Money Follows the Person Staff and Transition Coordinators to disclose my/the MFP Applicant's name, location and health information related to the transition process to the following agencies:

Description of Agency	Reason for Contacting	Notes
The facility in which you currently live (for example, the social worker and billing specialist there).	To begin transition coordination process To ensure your eligibility for this Project	
The Medicaid entity that oversees case management services in your area.	To ensure they can participate in the planning process.	Examples include: Local CAP DA Lead Agency or the "MCO."

Description of Agency	Reason for Contacting	Notes
The Division of Vocational Rehabilitation's Independent Living Office	To help coordinate the transition process (if applicable) To access supports around home modifications and assistive technology (as applicable)	This may not be necessary for every MFP participant
The local Department of Social Services (DSS) (for example, the Medicaid Representative)	To help clarify questions about your Medicaid enrollment or possible deductible status.	
The local agency that will be doing our follow up Quality of Life Surveys and may provide benefits counseling.	To help identify local resources that may be helpful in transitioning and to conduct MFP Quality of Life Surveys.	These are agencies under contract with DHHS to provide options counseling or other services. These agencies are usually local nonprofit organizations and are under the same privacy requirements as MFP.
IMPORTANT **If you have concerns about MFP staff and transition coordinators contacting any of the entities listed above, please explain here:**		

ADDITIONAL INFORMATION ABOUT SHARING HEALTH INFORMATION AND YOUR PRIVACY

* MFP Project Staff is happy to provide additional explanation if you have any questions about information below.

☐ I understand that this authorization will expire on the following date, event or condition:

One year after I transition under MFP or if I decide to leave the MFP program

☐ I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

☐ I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

☐ I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

☐ I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	(Date)	(Witness-If Required)
_____	_____	_____
(Signature of Personal Representative)	(Date)	(Personal Representative Relationship/Authority)

NOTE: This Authorization was revoked on _____ _____
Date (Signature)