

# 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:				Applica	ant's SSN:			
MFP Applicant's Na	ame (Last Name, F	First Na	ame, MI):	Date of	Birth:	Sex:		
Medicaid Number:		Medic	are Numl	ber:				
Facility Name and	Address:				Facility Co	ounty:		
racility Name and A	Address.				racinty Co	Junty.		
Facility Social	Name:		Phone:		Email (pref	ferred) or Fax:		
Worker/Point of Contact								
Date of Admission	to this Facility:							
	Complete Inf	ormed	Consent	(see atta	ached)			
		Offica	Oorisciit	(SCC arre	doned)			
Helpful Informatio	n: Having this Info	ormatic	on Will Ke	ep the P	rocess Mov	ving as Quickly as		
		Po	ssible					
Type of Facility:								
☐ Skilled Nursing F	acility		Acut	e Care H	lospital			
	e Facility for People	e with	☐ Psyc	hiatric R	esidential T	reatment Facility		
Intellectual Disabi			Othe	er (list he	re):			
Does a family mem person assume pri	. •				ne relationsh			
authority for this a	_	ikiiig	I ·	//Friend—r //Friend—(	• .	nsibility for applicant		
Yes No No			☐ Family	//Friend—I	Power of Attorn	•		
					egal Status Un	known		
Name and Phone r	number of Primary	/ Famil		izational G		Contact:		
Traine and Fibrie		, i aiiiii	y member	or other		Jonitaot.		
Estimated Transition	on Date:					Estimated Transition Date:		

Completing the Application			
Name of Person Comple	ting/Assisting with App	olication:	
Organization Name (if a	oplicable):		
Phone:	Fax:	Email:	
Affiliation (check one):			
☐ Self, no help		Family, Friend or Corporate Guardian	
Local Contact Agency		Center for Independent Living	
☐ Facility listed above		Private Medicaid Provider	
☐ MCO		DVR-IL	
CAP DA Lead Agency		Civic/Advocacy Group Not Otherwise Listed	
Area Agency on Aging		PACE	
Other (please list):			
About Me: My	y Community-Based Liv	ving Support Needs and Interests	
	•	ect your application to the right transition meets with Project requirements	
Type of Housing do you	prefer (check one):		
☐ My own home/apartme	ent [	Group home of four people or less	
│ │	tment	(Individuals with Intellectual Disabilities only)	
		Alternative Family Living/ "AFL"	
		(Individuals with Intellectual Disabilities only)	
Do you currently have a facility	/?	Do you need assistance with finding housing?  Y \[ \] N \[ \]	
If you have housing, list h	ome/apartment address:		
County you prefer to liv			

#### **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 N	le: My Commun	nity-Based Living	Support Needs a	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 in	ectly (even if son	<u> </u>	on? (Check One) Facility staff	
else needed to ph  A family member, to the applicant	,		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 <a href="mailto:mfpinfo@dhhs.nc.gov">mfpinfo@dhhs.nc.gov</a>

	MFP sta	aff use only	
Date Completed Medicar Part A Rehab:	e 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 (Prin	name)		
(Sign	ature)		(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"

 $\checkmark$ 

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 one 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.

oxdot YES, I have read this section and understand what it m
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#### **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	S, I have read this	Section ar	nd understand	the "basic	s" of the	<b>Transition</b>	Year
Stability	y 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.

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 365<sup>th</sup> 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.

$\square$ 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.

☐ YE	S, I understand	this Enrollment	and Re-Enrollment	Policy.
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#### 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.
$\square$ 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

Date

Signature of Guardian or Authorized Representative (if applicable)



### 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	
Γο ensure a coordinated and	organized transition to a new place of residence,
•	(MFP Applicant or Authorized Representative) Follows the Person Staff and Transition Coordinators to disclose my/the Ition and health information related to the transition process to the

Description of Agency	Reason for Contacting	Notes
The facility in which you currently live (for example, the social worker	To begin transition coordination process	
and billing specialist there).	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	To help coordinate the transition process (if applicable)	This may not be necessary for every MFP participant	
Rehabilitation's Independent Living Office	To access supports around home modifications and assistive technology (as applicable)		
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 information below.	additional	explanation if you have any questions about				
☐ I understand that this authorization	☐ I understand that this authorization will expire on the following date, event or condition:					
One year after I transition under MF	•	•				
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.						
the information; however, if this in	formation is in the contract i	rotected from re-disclosure by the requester of s protected by the Federal Substance Abuse not re-disclose such information without my provided for by state or federal law.				
related conditions, alcohol abuse, genetic testing this disclosure will in to sign this authorization and that treatment, payment for services, or by a non-treatment provider (e.g., in information (e.g., physical exam),	drug abus clude that it my refus my eligibilities surance conservice ma	nation relating to HIV infection, AIDS or AIDS- se, psychological or psychiatric conditions, or information. I also understand that I may refuse al to sign will not affect my ability to obtain by for benefits; however, if a service is requested company) for the sole purpose of creating health ay be denied if authorization is not given. If the 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)				