**Form 1580**



August 2020-E

Texas Money Follows the Person Demonstration (MFPD) Project

**Informed Consent for Participation**

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| Name | Social Security No. |
| Client Assignment and Registration (CARE) ID (Home and Community-based Services Waiver Only): |

# You Should Know That:

* The State of Texas would appreciate your being a part of this process.
* This is a very important project that will help eligible Texans move from institutions back into the community.
* Participation is voluntary.
* If you do not join the project, you can still receive Medicaid home and community-based waiver services if you meet the eligibility requirements.
* These waiver services can help you to move from your current place into a community setting.
* You could lose waiver and/or demonstration services because:
	+ your health or functional abilities get better; or
	+ you have too much money.
* You can pull out from the project at any time.

# Complaints:

Contact MFPD Project Director, 4900 North Lamar Blvd., Mail Code 4100, Austin, TX 78751, or by email at ,MFP-Project@hhsc.state.tx.us or by telephone at 512-424-6516.

# Consent

You will be given a signed copy of this consent form to keep.

I agree to participate in the project: Yes No

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| **MFPD Applicant Acknowledgment** |
| Signature of Applicant or Authorized Representative | Date Signed |
| Address | Telephone No. (include area code) |
| **MFPD Acknowledgment (if member is under 18 years old)** |
| Signature of Parent/Legally Authorized Representative (LAR) | Date Signed |
| Address | Telephone No. (include area code) |
| **/Local Intellectual and Development Disability Authority (LIDDA) or Managed Care Organization (MCO) Service Coordinator/ MFPD Acknowledgment** |
| I have read and explained this document to the applicant. I believe that he/she (or the LAR, if signed) understood the document. I verified the individual resided in an institutional setting (nursing facility, intermediate care facility for individuals with an intellectual disability or related conditions, state supported living center or hospital) for 90 continuous days prior to enrolling into STAR+PLUS Home and Community Based Services (HCBS) or Home and Community-based Services (HCS). |
| Signature | Date Signed |
| Address | Telephone No. (include area code) |
| **For Official Use Only (Completed by LIDDA or MCO Service Coordinator/)** |
| Estimated Date of Discharge | Telephone No. (include area code) |
| Name of Institution | Address of Institution |