



# MFP CBAY Treatment Choice Form

## What is a Psychiatric Residential Treatment Facility?

Psychiatric Residential Treatment Facility (PRTF) services are designed to be short term interventions that stabilize targeted behaviors. Your child will be placed in a residential facility outside of the home. A facility will typically provide services such as therapy, psychological assessments, and on-site educational programs. Day to day operations of a residential facility follow a strict, regimented, structured schedule. The facility is also responsible to work with the family to develop a transition plan into the community once treatment goals and objectives are met and level of care criteria are no longer appropriate.

## What is MFP CBAY (Money Follow the Person Community Based Alternatives for Youth)

MFP CBAY is a waiver designed to provide psychiatric residential treatment facility-level community based services in the home through an individualized Wraparound planning process. A Care Management Entity (CME) of your choice will help you prioritize your family's needs through a child and family team process designed to build on your family strengths. These strengths are used to meet developed goals and objectives while building on your already existing natural and community support system. This process is an alternative to PRTF to build supports in the family's home and community so the family can remain together.

This process's values include:

- **Voice** – The child and family are active partners in making treatment decisions.
- **Team** – The approach must involve a team consisting of members of those social systems (family, school, community, neighbors, church) who are most important to the child.
- **Community Based** – Mental health treatment success is best achieved in the community in which the child lives.
- **Culturally Competent** – The process must be built on each family's unique values, preferences, and strengths.
- **Individualized** – Every child has different needs and abilities and treatment plans reflect this. As part of this, you, as the parent/guardian, have the right to have a choice of the services and service providers that you receive.
- **Strengths Based** – Mental health treatment success can be best achieved if we focus not only on the problems of a child and family but also what is going well and is healthy about the family.
- **Natural Supports** – The use of informal community supports such as neighbors, church or friends is important to the success of children.
- **Continuity of care** – Unconditional commitment to continue to help the families through whatever services are necessary to meet treatment goals.
- **Collaboration** – The child is best treated if all the important systems in her life are working together towards similar goals.
- **Flexible Resources** – It is important to be able to flex resources towards what the team believes is most important to the mental health needs of the child.

Along with this process, you will have access to additional support services.

**Outcome based services** – Goals and services must be measured and treatment adjusted to improve outcomes. You will be interviewed every three months by family support staff and university staff to collect the information needed to evaluate if you are receiving the services you need and are satisfied with everything you are receiving. These services include:

- o Respite
- o Waiver Transportation
- o Care Management
- o Family Peer Support Services
- o Financial Support Services
- o Expressive Clinical Services
- o Clinical Consultation Services
- o Youth Peer Support Services
- o Community Transition
- o Customized Goods and Services
- o Supported Employment
- o Behavioral Assistance

Participation in MFP CBAY demonstration services is voluntary and you may choose to discontinue services at any time.

Based on the above information, I, \_\_\_\_\_,

Parent/guardian of \_\_\_\_\_, formally request

- Psychiatric Residential Treatment Facility Services       MFP CBAY Services with my chosen CME being:
- View Point Health (formerly GRN)
  - Lookout Mountain Care Management Entity

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# MFP CBAY Unified Release of Information

Participant First Name: \_\_\_\_\_ MI \_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Section A1: Use or Disclosure of Health/Education Information

### Section A2: Use or Disclosure of Health/Education Information

By signing this form, I authorize the disclosure of my individually-identifiable health/education information **by** the following:

- Juvenile Court
- Care Management Entity (specify) \_\_\_\_\_
- Department of Juvenile Justice
- Department of Family and Children Services
- Mental Health Provider(s) (specify): \_\_\_\_\_

- School(s) (specify): \_\_\_\_\_
- Wraparound Evaluation Team
- Medical Provider (specify): \_\_\_\_\_
- Other organizations providing services to you and your family (specify) \_\_\_\_\_

Other \_\_\_\_\_

By signing this form, I authorize the disclosure of my individually-identifiable health/education information **to** the following:

- Juvenile Court
- Care Management Entity (specify) \_\_\_\_\_
- Department of Juvenile Justice
- Department of Family and Children Services
- Mental Health Provider(s) (specify): \_\_\_\_\_

- School(s) (specify): \_\_\_\_\_
- Wraparound Evaluation Team
- Medical Provider (specify): \_\_\_\_\_
- Other organizations providing services to you and your family (specify) \_\_\_\_\_

Other \_\_\_\_\_

### Section B: Scope & Use of Disclosure

Information that may be used or disclosed based on this authorization is as follows (check one):

- All health information about me, including medical records created or received by the Provider. This information may include, if applicable:
  - Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse, mental health disorders, educational issues/needs, legal issues/needs and/or social/recreational issues/needs.
  - Services provided by the above agencies during the period of this release
  - Services provided by the above agencies prior to this release
  - Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
  - Privileged communications between me and a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning my communications with them.
- All health information about me as described in the preceding checkbox, excluding the following: \_\_\_\_\_
- Specific health information **including only** the following: \_\_\_\_\_
- All education information about me, including education records. This information may include, if applicable: report cards, attendance, discipline, IEP, 504 plan, evaluation

### Section C: Purpose of Use or Disclosure

The purpose for this disclosure is (check one):

- Specifically, the following \_\_\_\_\_
- The youth chooses not to disclose the purpose. NOTE: This box may NOT be checked if the information to be disclosed pertains to alcohol or drug abuse information.

### Section D: Expiration

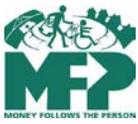
NOTE: If an expiration event is used, the event must relate to the youth or the purpose for the disclosure  
Event \_\_\_\_\_

Consent for Release of Health Information expires 12 months from the date it was signed. Consent for Health Information must last no longer than "reasonably necessary to serve the purpose for which consent is given". 42 CFR 2.31 (a)(9)

### Section E: Other Important Information

1. I understand that the System of Care agencies cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a youth in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).
2. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain services.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the System of Care in reliance on this authorization before written notice of revocation is received.
4. I understand that educational records are confidential under state and federal law and by signing this Unified Release of Information; I am authorizing the release of educational records.

Date	Signature of Participant
Date	Signature of Parent/Legal Guardian
Date	Signature of Witness (Title):



## MFP CBAY Overview and Consent

### Introduction

Community-based Alternatives for Youth (MFP CBAY), serves children and youth ages 5 through 17 and youth or young adults ages 18 through 21 with serious emotional and behavioral disturbances who have a primary diagnosis of mental illness as identified in the DSM-IV and who are placed, or at risk of placement, in a Psychiatric Residential Treatment Facility will be served by the program as close to their natural home settings as possible. MFP CBAY uses a systems approach that targets youth served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive behavioral system that ensures youth are placed in and remain in intensive residential treatment only when necessary and that a coordinated system of services at the community level is available. The state's entire system relative to youth is being transformed to ensure that evidence-based practices, as well as an array of quality services, are available, integrated, and supported throughout Georgia. Moving forward the youth previously enrolled and active by September 30<sup>th</sup>, 2012, will be sustained in the program until they graduate or age out of the program. The Money Follows The Person (MFP) Rebalancing Demonstration grant will support funding for MFP CBAY youth eligible for MFP services.

### Evaluation Component

If you choose to participate in the MFP CBAY demonstration project there will be an on-going evaluation component conducted through your CME (Care Management Entity) and the Georgia State University staff. Your participation is entirely voluntary, and you can withdraw your consent at any time without penalty. If you choose to participate, you will be expected to complete the evaluation tools as requested. These results will be anonymous. You will be asked to complete the following evaluation tools by the respective organization:

- WFI-4 (Wraparound Fidelity Index)
- YSSF (Youth Satisfaction Survey Family)
- CANS (Child and Adolescent Needs and Strengths)
- CIS (Columbia Impairment Scale)
- CHKS (California Healthy Kids Resiliency Survey)
- FES (Family Empowerment Scale)
- MFP QOL (MFP Quality of Life Survey – for participants 18 to 21 years of age)

The evaluations will be completed either by phone or in person. Staff may explain the evaluation instrument and assist you in understanding the questions that are asked, however, your answers are confidential and you should not be persuaded to answer any question a certain way. Participation in this project does not involve any risk or stresses.

If you have any questions regarding the evaluation component, please contact Linda Henderson-Smith at 404-657-6087 or by email at [lyhenderson@dbhdd.ga.gov](mailto:lyhenderson@dbhdd.ga.gov).

***I have read and understand the above information.***

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Instructions for Completing Minimum Data Set (MDS)

**What is the MDS?** The MDS (Minimum Data Set) is required data collected for each youth for the National Evaluation submitted to MFP CBAY staff on a quarterly basis.

**Who should fill out the MDS?** The care provider who completed the PRTF application is responsible for completing the MDS. After APS notifies MFP CBAY staff of an approval referral, MFP CBAY staff will then email the core provider requesting the completed MDS form. Service **cannot** be authorized without this document.

**When should the MDS be completed?** The MDS is completed at intake, every 3 months thereafter, and at discharge.

**Where is the MDS kept?** The MDS form is kept in each client's folder in a locked designated cabinet.

**What guidelines should be followed in completing the MDS?** Please see the following chart below for additional assistance with completing the MDS form.

- Make sure completed dates are entered in required fields.
- Check for accuracy of information.
- Make sure family understands what information/questions are being asked.
- Complete all fields!

Data	Instructions
Medicaid ID#	Enter participant's Medicaid Id # <b>Format:</b> 12 digits (ex: 111565656565)
CID Eligibility #	Enter CID # received from CBAY MFP staff <b>Format:</b> 9 digits (ex: 3001111111)
Record Trail	Select collection period for participant's data
Date of data collection	Enter date data was collected <b>Format:</b> mm/dd/yyyy (ex: 11/07/2009)
Enrollment #	Enter # of times participant has enrolled in the program
Demographic & Family Data Section	
Data	Instructions
Date of Birth	Enter participant's DOB <b>Format:</b> mm/dd/yyyy (ex: 10/15/1993)
Gender	Select participant's gender
Race	Check participant's race
Ethnicity	Check participant's ethnicity
Current Caregiver	Check participant's current caregiver
Current living arrangement and/or residential placement	Check participant's current arrangement
Total annual family income in the past year	Enter income <b>Format:</b> \$##,### (ex: \$20,000)
Would youth be Medicaid eligible for non-waiver home-based services	Check Yes or No
Health & Health Care History Section	
Data	Instructions
DSM-IV Diagnosis: Primary	Enter participant's diagnosis <b>Format:</b> ###.## (ex: 321.23)
DSM-IV Diagnosis: Secondary	Enter participant's diagnosis <b>Format:</b> ###.## (ex: 321.23)
Age at first receipt of mental health services	<b>Format:</b> ## (ex: 12)
# of PRTF admissions to date:	Enter total # of participant's PRTF admissions <b>Format:</b> ##. (ex: 10)
Date of first ever PRTF admission	Enter date of participant's 1 <sup>st</sup> PRTF admission



	<b>Format:</b> mm/yyyy (ex: 12/2006)
Date of admission at most recent PRTF stay	Enter date of participant's most recent PRTF admission <b>Format:</b> mm/yyyy (ex: 12/2006)
Date of exit at most recent PRTF stay	Enter date of participant's recent PRTF exit <b>Format:</b> mm/yyyy (ex: 12/2006)
Date of first admission to waiver services	MFP CBAY staff will enter this date at intake. Enter MFPCBAY approval date when completing follow-up <b>Format:</b> mm/dd/yyyy (ex: 10/15/2006)
Date of discharge/enrollment from the waiver services	Enter date if participant is being discharged from MFP/CBAY <b>Format:</b> mm/yyyy (ex: 12/2006)
Common Functional Assessment Items Section	
Data	Instructions
Days in PRTF	<b>Format:</b> ### (ex: 115)
Days in psychiatric hospital	<b>Format:</b> ### (ex: 15)
Days in out-of-home placements	<b>Format:</b> ## (ex: 0)
# of unexcused absences from school in the past 6 months	<b>Format:</b> ###: (ex: 10)
# of excused absences from school in the past 6 months	<b>Format:</b> ###: (ex: 15)
School absences severity	Check participant's severity level
Severity of substance abuse use	Check participant's severity level
Number of arrests in the past 6 months	Enter total # of participant's arrest <b>Format:</b> ## (ex: 10)
Any involvement with law enforcement in the past 6 months?	Select Yes or No
Has the youth been involved with Child Protective Services in the past 6 months?	Select Yes or No

## Changes to MDS

There have been changes to the Minimum Data Set Form (MDS). **ALL** MDS data submitted must be as complete as possible, each time it is submitted.

MDS changes include:

- CID Eligibility # has been added.
- Record Trail: Additional monthly follow-up boxes have been added.
- Enrollment # will always be 1 for each youth unless they have been discharged previously.
- In the Environmental Variables & Common Functional Assessment Items sections, all fields are for data collection in the **past 6 months** unless otherwise denoted.
- Received psychosocial rehabilitation services' in the Environmental Variables section has been changed to 'Received core/specialty services'.
- A non-applicable (N/A) section has been added to the Environmental Variables section. Please use this section if the data is not applicable to the youth in question. Also, rather than leaving information blank, please write N/A for any other data fields that do not apply to the youth.



### Minimum Data Set Form

Medicaid ID #:	CID Eligibility #:	Record Trail: <input type="checkbox"/> Baseline <input type="checkbox"/> Discharged <input type="checkbox"/> 3-Month <input type="checkbox"/> 6-Month <input type="checkbox"/> 9-Month <input type="checkbox"/> 12-Month <input type="checkbox"/> 15-Month <input type="checkbox"/> 18-Month
Date of data collection: / /	Enrollment #: _____	

#### DEMOGRAPHIC & FAMILY DATA

Date of Birth (mm/dd/yyyy): / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Race : <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic	
Current Caregiver: <input type="checkbox"/> Biological parent <input type="checkbox"/> Step-parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Live-in friend/relative <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other	
Current living arrangement and/or residential placement: <input type="checkbox"/> Family or relative's home <input type="checkbox"/> Foster care home <input type="checkbox"/> Therapeutic foster care <input type="checkbox"/> Detention/jail <input type="checkbox"/> Other residential setting	
Total annual family income in the past year: \$	Would youth be Medicaid eligible for non-waiver home-based services? <input type="checkbox"/> Yes <input type="checkbox"/> No
Guardian Name:	Guardian Phone:
County where Youth will be living:	County of Residence:
Address where Youth will be living during CBAY MFP Project:	

#### HEALTH & HEALTH CARE HISTORY

DSM-IV Diagnosis: Primary	DSM-IV Diagnosis: Secondary
Age at first receipt of mental health services:	# of PRTF admissions to date:
Date of first ever PRTF admission (mm/yyyy): /	Date of admission at most recent PRTF stay (mm/yyyy): /
Date of exit at most recent PRTF stay (mm/yyyy): /	Date of first admission to waiver services (mm/dd/yyyy): / /
Date of discharge/enrollment from the waiver services (mm/yyyy): /	

#### ENVIRONMENTAL VARIABLES

	YES	NO	N/A
Diverted from the PRTF (Only at Intake)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transitioned from PRTF (Only at Intake)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had ever moved in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever been in foster care in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received vocational counseling/ employment services in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had contact with unemployment office in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had contact with any special education program in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received core/specialty services in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Received supported employment services in the past 6 months:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### COMMON FUNCTIONAL ASSESSMENT ITEMS

Days in PRTF in the past 6 months :	Days in psychiatric hospital in the past 6 months :	Days in out-of-home placements in the past 6 months :
# of unexcused absences from school in the past 6 months : _____	# of excused absences from school in the past 6 months : _____	
School absence severity : <input type="checkbox"/> Youth attends school regularly <input type="checkbox"/> Some attendance problems, but generally attends <input type="checkbox"/> Problems with school attendance (missing 2 days each week) <input type="checkbox"/> Generally truant or refusing to go to school	Severity of substance abuse use: <input type="checkbox"/> No <input type="checkbox"/> Mild/occasionally <input type="checkbox"/> Moderately <input type="checkbox"/> Severe	
Number of arrests in the past 6 months: _____	Any involvement with law enforcement in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the youth been involved with Child Protective Services in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No



### Minimum Data Set Form (Cont.)

#### SUBSCALE SCORES FROM CAFAS

School/Work Role Performance Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30	Community Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30
Substance Use Subscale Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30	Moods/Emotions Subscale Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30
Self-harmful Behavior Subscale Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30	Thinking Subscale Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30
Family/Social Support Subscale Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30	Behavior towards others Subscale Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30
Home Role Performance Subscale Score : <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30	

#### RISK BEHAVIORS FROM CAFAS

YES

NO

##### COMMUNITY LIVING

Has been or may be harmful to others or self due to others or self due to aggression in the community:



##### SCHOOL FUNCTIONING

Has been or may be harmful to others or self due to aggression at school:



##### ALCOHOL & OTHER DRUG USE

Severe substance use:



##### MENTAL HEALTH

Psychotic or organic symptoms in the context of severe impairment:



Has made a serious suicide attempt or is considered to be actively suicidal or possibly suicidal:



##### FAMILY FUNCTIONING & HOME ROLE

Runaway Behavior in the past 3 months:



Has been or may be harmful to others or self due to aggression at home in the past 3 months:



##### OTHER DATA REQUESTS

School grades are average or above:



Serious and/or repeated delinquent behavior in the past 3 months:



Use is such a way as to interfere with functioning:



Does not engage in peer interactions or in making new friends due to negative behavior: (e.g. teasing, ridiculing, picking on others)



Does not engage in typical peer recreational activities b/c of tendency to be ignored or rejected by peers:



Family not able to provide adequate warmth, security or sensitivity relative to the youths needs:



Parent supervision is adequate:



# MFP CBAY Referral Form

Date of referral (mm/dd/yyyy): \_\_\_\_\_

Person making referral: \_\_\_\_\_

Agency making referral: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Person Referred-Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_

Inpatient Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Admission Date to inpatient facility (mm/dd/yyyy): \_\_\_\_\_

Anticipated Referral: CCSP  SOURCE  ICWP  Date Referred: \_\_\_\_\_  
NOW  COMP  CBAY  Date Referred \_\_\_\_\_

Currently on wait list for: CCSP  SOURCE  ICWP   
NOW  COMP  CBAY

Letter or contact info from the waiver: Yes  No

Case Mgr/Care Coordinator if assigned \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Interested Parties:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Pertinent Information: \_\_\_\_\_

Return completed referral form by Email to: [cbayreferrals@dhr.state.ga.us](mailto:cbayreferrals@dhr.state.ga.us) Or mail completed form to:

**Community Based Alternatives for Youth (CBAY)**  
**Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)**  
**2 Peachtree St. NW, 23rd Floor**  
**Atlanta, GA 30303**  
**Attention: MFP CBAY Referral**

For questions or assistance making a MFPCBAY referral, contact Dr. Linda Henderson-Smith at 404-657-6087.



## Money Follows the Person Informed Consent for Participation

I, \_\_\_\_\_, (print name) voluntarily agree to be screened and assessed as part of my application for participation in the Money Follows the Person (MFP) project<sup>i</sup>. MFP Field Personnel will determine my appropriateness for the project. If approved for the MFP project, my participation may be in segments or consecutive days, but for a total period not to exceed 365 calendar days<sup>ii</sup>.

By signing this Informed Consent, I agree to participate in all aspects of the MFP project, including completing the *Quality of Life Survey*. My responses to the *Quality of Life Survey* and other program information will be shared with the Centers for Medicare and Medicaid Services (CMS) as well as Georgia and national evaluators.

I have been given information about the MFP project; a copy of the MFP Brochure and a copy of the *Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia* booklet. I understand the MFP project guidelines including enrollment requirements. I understand that MFP one-time transitional services are provided under the MFP demonstration project.

I understand that if I qualify for and am enrolled in an appropriate waiver program, waiver services will continue for as long as I need them and I continue to meet eligibility requirements. If I am no longer eligible for the Medicaid waiver program, I will be provided with other service options that may assist me in a community setting. I understand that certain circumstances will make me ineligible for a waiver and for MFP. If the total cost of providing my care under the waiver exceeds the cost of providing care in an inpatient facility, I will become ineligible for the waiver and for the MFP project. If my condition improves and I don't continue to meet the waiver Level of Care criteria, I will become ineligible for the waiver program and may become ineligible for the MFP project.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
If signed by Responsible Party, State Relationship and Authority to Sign

\_\_\_\_\_  
MFP Field Personnel Sign Date

<sup>i</sup> Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304

<sup>ii</sup> If the MFP participant needs to be readmitted to an inpatient facility for a period of 30 days or less, the participant remains enrolled in the MFP demonstration. As soon as the participant's condition stabilizes, the participant can return to the community and resume services. When an MFP participant is readmitted into an inpatient facility for a period of time greater than 30 days (31 days or longer), the participant is discharged from the MFP demonstration and is considered an institutional resident. However, the discharged MFP participant will be re-enrolled, prior to the completion of 365 days, back into the demonstration without re-establishing the 90-day institutional residency requirement. The individual is considered an MFP participant when discharged from the inpatient facility, and is eligible to receive MFP services for any remaining days up to 365. MFP field personnel determine if any changes to the participant's Individualized Transition Plan are needed to prevent a re-admission to an inpatient facility. If the participant is readmitted to an inpatient facility for a period of longer than six months, the participant will be re-evaluated like a "new" MFP participant.



## MFP Release of Health Information (MFP RHI)

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. Failure to provide *all* information requested may invalidate this Authorization.

### USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the release, use or disclosure of my health information as follows:

Member Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Health Plan Name: \_\_\_\_\_

Persons/Organizations authorized to *receive, use or disclose* the information <sup>i</sup> are:

- MFP Field Personnel \*
- Waiver assessment/case management staff \*
- My Representative (Legal, etc.) \*
- MFP service providers (Peers, Ombudsman, etc.) \*

*\* Personnel located in Georgia and in the state to which you are transitioning.*

Purpose of requested use or disclosure: <sup>ii</sup> for screening and assessment and participation in MFP. This Authorization applies to the following information (select **only one** of the following):<sup>iii</sup>

- All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: \_\_\_\_\_

- Only** the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

\_\_\_\_\_  
\_\_\_\_\_

### EXPIRATION

All information I hereby authorize to be obtained from this inpatient facility will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for: (PLEASE CHECK ONE)

- ninety (90) days unless I specify an earlier date here: \_\_\_\_\_
- one (1) year
- the period necessary to complete transactions related to my participation in Money Follows the Person on matters related to services provided to me through Money Follows the Person.

*I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.*



## MFP Release of Health Information (MFP RHI)

### NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: \_\_\_\_\_

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.<sup>iv</sup>

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.<sup>v</sup>

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

\_\_\_\_\_  
Signature of Member or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Representative, State Relationship or Basis of Authority

<sup>i</sup> If the Authorization is being requested by the entity holding the information, this entity is the Requestor.

<sup>ii</sup> The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

<sup>iii</sup> This form may not be used to release both psychotherapy notes and other types of health information (see 45 CFR § 164.508(b)(3)(ii)). **If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.**

<sup>iv</sup> Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR § 164.508(d)(1), (e)(2)).

<sup>v</sup> If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. **Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.**