Department of HUMAN SERVICES

Money Follows the Person
Consent to Proposed Transition

I, _____, have reviewed the comprehensive
(Facility resident/parent/guardian/legal rep)

assessment, transition plan, and proposed supports for a move by

_____ from _____ to _____.
(Facility Resident) (Facility Name) (Community provider, location)

I understand that supports essential to health and safety will be in place and available to _____ by the time of the move, and non-
(Facility Resident)

essential supports also important for health, safety and quality of life will be in place within 60 days of the move.

I understand that _____ will provide post-transition follow-up
Transition Specialist

within two days of the move, and monthly thereafter.

I understand that participants in Iowa's *Partnership for Community Integration* (Money Follows the Person) demonstration are expected to participate in periodic surveys to determine customer satisfaction and quality of life. I have been given a copy of the transition plan, and have had the opportunity to discuss it, ask questions, and provide input regarding the proposed supports.

I understand that Iowa's *Partnership for Community Integration* demonstration is providing the financial support for this transition and for the essential and nonessential services and supports necessary to maintain community living for no more than 365 days following the date of transition. I understand that the *Partnership for Community Integration* demonstration is subject to the terms of the federal Deficit Reduction Act governing Money Follows the Person grants, and that, under the terms of the State of Iowa's grant contract with the Centers

for Medicare and Medicaid Services, _____, as a
(Facility Resident)

participant in the *Partnership for Community Integration* is entitled at the end of his/her demonstration year to enroll in an HCBS Waiver appropriate to his/her needs. I understand that the Waiver in which he/she enrolls will make available to him/her most, but not necessarily all, of the supports and services in his/her Transition Plan. The services to be available are subject to action by the Iowa Legislature and by the Centers for Medicare and Medicaid Services.

I do/do not give my consent for this transition to occur. I further understand that I may withdraw my consent at any time prior to the proposed move by calling _____ at _____. The revocation will take
(Transition Specialist) (Phone No.)

effect on the date it is received. In any event, this authorization will automatically expire one year from the date of my signature, or, if applicable, upon the termination of my legal authority to act on behalf of the Facility Resident named above.

Signature _____ Date _____

Relationship to Facility Resident _____