INFORMED CONSENT & AUTHORIZATION

Name: _____ **Medicaid ID #:** _____

Home Again assists people living in institutions to move back to the community and to live successfully in their own home and community. Participation in South Dakota's Home Again program is open to any who meet the following eligibility criteria:

1. South Dakota resident;
2. Is a resident of a nursing facility or intermediate care facility for more than 60 consecutive days OR hospitalized for more than 30 days OR in their home but at-risk for facility placement;
3. Meets Medicaid eligibility criteria prior to transition or first contact in the home;
4. Is willing to enroll in and can be supported in the community through the provision of existing home and community-based services (HCBS); and
5. Expresses a desire to live and receive HCBS

Participation is voluntary. However, if you choose to participate, you must:

- Work with the Transition Coordinator to identify members of the Transition Team that will help plan for a successful transition to the community or to remain in the community;
- Participate in three surveys about your quality of life: prior to transition (or at initial contact if already in the home), 11 months and 24 months thereafter
- Accept supportive services via HCBS, as appropriate

Any information collected about you will be confidential and used only for evaluating the program. You may withdraw from participation in the Home Again program at any time. If you choose not to sign this form, your decision will not affect your eligibility to receive Medicaid, to remain in the present facility, or to apply for existing Medicaid home and community-based services (HCBS). Home Again provides support for 365 days. Upon conclusion of the Home Again program, your waiver services will continue, with no interruption of services as long as you remain eligible. Home Again helps to get you back to your home and community; HCBS helps to keep you there.

You or your representative has the right to report concerns or complaints either verbally or in writing to the Home Again Program Director and/or Transition Coordinator. The complaint process does not take away your right to a fair hearing, your right to refer to Constituent Services of Dept. of Social Services, or your right to use other available reporting mechanisms.

AUTHORIZATION FOR RELEASE OF INFORMATION AND CONSENT

I hereby authorize the South Dakota Department of Social Services (DSS) and/or its designee to use, reproduce, publish, and broadcast images of me and/or my property in any media (i.e., photographs, presentations, digital images, posters, video, newsletters, pamphlets, or other publications) to be used only for the following purposes: awareness, education, information, and promotion of the Home Again program. This authorization is expressly intended to release DSS and its personnel from any and all liability which may result from the use of materials. I will not make any claims against DSS for compensation of these services.

By signing below, I understand and acknowledge that:

- My participation is voluntary and am not required to sign this form. If I refuse to sign, it will not affect treatment, payment, enrollment, or eligibility for medical services. It is your choice to participate in the Home Again program or not.

- When disclosing my information pursuant to this authorization, DSS will reference me only by my first name or pseudonym; my surname will not be disclosed. The name I would like DSS to use is

  (If I do not list a response, my first name will be used upon signing this form.)

  _____

- This authorization shall expire when revoked in by me in writing. Written revocation shall be mailed to Division of Medical Services, ATTN: Home Again Program, 700 Governors Drive, Pierre, SD 57501 (If I revoke or cancel this authorization, the revocation is not effective for the use or disclosure of information that has already occurred.)

- I acknowledge my understanding of the Home Again program; and accept participation in the Home Again program if determined to be eligible.

Home Again participant acknowledgement

Printed name: _____

Participant signature: _____ **Date:** ____/____/_____

Guardian/Legal representative acknowledgement (if applicable)

Printed name: _____

Guardian signature: _____ **Date:** ____/____/_____

Mailing address: _____ **Email:** _____

City, State, Zip: _____ **Phone:** _____