

Money Follows the Person

Consent to Proposed Transition

I, _____, have reviewed the comprehensive
ICF/ID resident/parent/guardian/legal rep
assessment, transition plan, and proposed supports for a move by
_____ from _____ to _____.
ICF/ID resident ICF/ID 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-
ICF/ID 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 _____
Transition specialist

will provide post-transition follow-up within two days of the move, at least twice
monthly within the first three months after the move, and quarterly 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 non-
essential 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
CF/ID 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 _____.
Transition specialist Phone no.

The revocation will take 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 ICF/ID resident named above.

Signature _____ Date _____

Relationship to ICF/ID Resident _____