



# Participant Consent for use of Monitoring Technology

**DRAFT FOR PUBLIC COMMENT PERIOD**

This form is for the use of monitoring technology funded through the Home and Community-Based Services waivers and the Alternative Care program. It includes information about the monitoring technology you decided to use. At the end of this form, you will need to sign your agreement for the use of monitoring technology. A case manager will help you fill out this form and keep a copy in your file.

## What is monitoring technology?

Monitoring technology is use of equipment to oversee, monitor and supervise someone receiving waiver services. It can help keep people safe and support independence. The equipment used may include alarms, sensors, cameras, and other devices.

## Participant's information

LAST NAME	FIRST NAME	MI	PMI	DATE OF BIRTH
Is participant under guardianship? <input type="radio"/> Yes <input type="radio"/> No	If yes, which type? <input type="checkbox"/> Private guardianship <input type="checkbox"/> Public guardianship performed by public agency <input type="checkbox"/> Public guardianship performed by private agency under contract		WAIVER TYPE <input type="checkbox"/> AC <input type="checkbox"/> BI <input type="checkbox"/> CAC <input type="checkbox"/> CADI <input type="checkbox"/> DD <input type="checkbox"/> EW	

## License holder (if applicable)

NAME	CONTACT PERSON	PHONE NUMBER
ADDRESS	CITY	STATE ZIP CODE

## I. How will monitoring technology be used?

Your case manager must collect/verify the following information from the provider.

### Description of monitoring technology

<p>What is the goal/outcome of the monitoring technology? (check all that apply)</p> <p><input type="checkbox"/> Address complex medical need* <input type="checkbox"/> Improve quality of supports <input type="checkbox"/> Increase independence <input type="checkbox"/> Reduce or eliminate critical incidents</p> <p><input type="checkbox"/> Address extreme circumstances* (such as)</p> <p><input type="checkbox"/> Other (describe)</p> <p style="text-align: right;">* The use of cameras or video equipment in bedrooms can only be used to achieve one of these goals.</p>
<p>What type of equipment will be used? (check all that apply)</p> <p><input type="checkbox"/> Cameras or video equipment <input type="checkbox"/> Mobile, on-person equipment such as body sensors, GPS <input type="checkbox"/> Audio listening equipment</p> <p><input type="checkbox"/> Sensors not located on the person, e.g., motion sensors or elopement alarms that record data (describe)</p> <p><input type="checkbox"/> Other (describe)</p>

Where will the monitoring technology be used? (check all that apply)

In a bedroom (All camera or video equipment in bedrooms require DHS approval)

In the living room, kitchen or other common area (describe)

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When will the monitoring technology be used? (check all that apply)

Morning (between 6 a.m. and noon)     Afternoon (noon to 6 p.m.)     Evening (6 to 11 p.m.)

Overnight (11 p.m. to 6 a.m.)     24-hours a day

Other (e.g., during specific activities or routines of the day. Describe)

**Monitoring technology’s impact on you**

My case manager and I have talked about how monitoring technology will affect me, including the following (a check in the left column indicates the item has been discussed, a check in the right column indicates it’s not applicable):

	DISCUSSED	DOES NOT APPLY	ISSUE
<input type="checkbox"/>			How my needs will be met if I do not choose monitoring technology (including but not limited to, needing in-person staff to supervise or assist me if I do not use the equipment).
<input type="checkbox"/>			How the use of monitoring technology affects my freedom of movement inside or outside my home.
<input type="checkbox"/>			The effect that using monitoring technology will have on my opportunities to go out into the community for outings or events.
<input type="checkbox"/>			Possible risks created by the use of monitoring technology and the plan for how and who will provide help if I need it. We have included this information into my Coordinated Service and Support Plan.
<input type="checkbox"/>			How monitoring technology is the least restrictive, as well as my preferred method, to meet my needs.
<input type="checkbox"/>		<input type="checkbox"/>	The conditions I want placed on how and when monitoring technology can be used. We have included these conditions in my Coordinated Service and Support Plan.
<input type="checkbox"/>		<input type="checkbox"/>	How to talk to shared roommate (if applicable and I choose to do so instead of my case manager doing so) about my monitoring technology and any impact it may have on them.
<input type="checkbox"/>		<input type="checkbox"/>	The video and audio recording must be stored securely and kept for five days (unless you or your legal representative ask for it to be held longer because of alleged maltreatment).

**II. Privacy and protection of personal information**

**Data collection**

What data or information will the monitoring technology capture?

Who will have access to the data collected through monitoring technology?  NOT APPLICABLE. NO DATA IS BEING COLLECTED

STAFF NAME AND/OR POSITION	AGENCY	LOCATION
1.		
2.		
3.		
4.		
5.		
6.		

(if additional, please attach on another sheet)

### Third party monitoring

Sometimes, an outside agency manages your monitoring. When that is the case, that agency may have access to your recorded information so it can alert your provider if necessary (Leave blank if this does not apply).

If a third party manages my monitoring, I authorize that third party, \_\_\_\_\_ to disclose the above data or information to the provider, \_\_\_\_\_.

- Yes  
 No

### My rights

I will have full control of when the equipment is on or off  Yes  No

**If your answer is “No,”** your Coordinated Service and Support Plan must:

- Describe the amount of control you will have to turn equipment on or off
- Describe the reason you do not have full control
- Identify who else will control the use of the equipment.

My case manager has explained each of the following to me (check those that apply):

- I have a right to stop or suspend monitoring technology**
- I may appeal a denial of monitoring technology**
- I have a right to privacy, except those times or situations identified in the Coordinated Service and Support Plan (Note: 245D licensed providers must comply with the rights restrictions process)
- I have a right to review information gathered during the use of monitoring technology
- I have a right to limit who can review private information gathered by monitoring technology
- I have a right to information about how the provider will use the monitoring technology data
- I have a right to review and request changes regarding the provider’s plans for how the monitoring technology is used
- I have a right to have the information collected through monitoring technology kept secure
- The information collected from the use of monitoring technology can be used in each of the following
  - Investigation of abuse, neglect or exploitation
  - Investigation of criminal activity
  - Legal proceedings.

### III. Participant/legal representative agreement

- This authorization expires 12 months from the date I sign this form, or before that, if I change my mind.
- I can change my mind and decide I do not want to give my consent for monitoring technology. To do this, I have two options:
  1. Notify my provider in writing, or
  2. Contact my case manager and say I no longer agree.(You can request assistance to contact your case manager, if needed.)
- My decision to allow, disagree with or change my mind about monitoring technology does not affect my treatment, payment, enrollment or eligibility for benefits.
- If I have additional questions, I can contact my case manager.

#### Agreement

- I agree to the use of monitoring technology as this document and my Coordinated Services and Support Plan describes it.
- I do not agree to the use of monitoring technology.

PARTICIPANT/LEGAL REPRESENTATIVE SIGNATURE	RELATIONSHIP TO PARTICIPANT:	DATE
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Was anyone else present during the discussion of this information? If so, please list here:

NAME	RELATIONSHIP TO PARTICIPANT	INITIALS
1.		
2.		
3.		
4.		
5.		
6.		

(if additional, please attach on another sheet)

### IV. What's next?

#### The case manager must:

1. Maintain a signed copy of this document in the participant's file
2. Give a copy to the participant or his/her legal representative.
3. Give a copy to the licensed provider (if applicable) to be maintained in the participant's Coordinated Service and Support Plan Addendum.