DSS-MS-146 (Revised 10/11)

# MEDICAID STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAM OF PROJECTS RECEIVING FEDERAL FUNDS.

## ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____. When I first asked for the
(*Doctor or Clinic)*
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.
I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.
I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.
I am at least 21 years of age and was born on _____
*Month/Day/Year*
I, _____, hereby consent of my own free will to be sterilized by _____ by a method called _____. My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed. I have received a copy of this form.

_____ Date:_____
*Signature* *Month/Day/Year*

You are requested to supply the following information, but it is not required:
Race and ethnicity designation (please check)

☐ American Indian or Alaska Native ☐ Black (not of Hispanic origin)
☐ Hispanic ☐ Asian or Pacific Islander ☐ White (not of Hispanic origin)

## ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
*Interpreter* *Date*

## ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ _____ signed the
*Name of Individual* *Recipient I.D.*
consent form. I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risk, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that serialization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
*Signature of person obtaining consent* *Date*

_____
*Facility*

_____
*Address*

## ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____,
*Name of individual to be sterilized Date of sterilization*
I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.
(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)
(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
☐ Individual's expected date of delivery:
☐ Emergency abdominal surgery:
(describe circumstances):

_____ _____
*Physician* Date

_____
*Physician NPI*

**ATTACH THE PROPERLY COMPLETED FORM TO MEDICAID CLAIMS RELATIVE TO STERILIZATIONS**

## *INSTRUCTIONS*

## *CONSENT FOR STERILIZATION*

**All fields in this section must be completed at the time of recipient signature.** The consent form must be signed by the recipient at least 30 days and no more than 180 days prior to sterilization surgery, and must include the following.

- Doctor's or clinic's name.
- Name of surgery.
- Month, day, and year of the recipient's birth.
- Recipient's name.
- Name of the doctor who will be performing the surgery.
- Name of the surgery. The name of the surgery given here must match all other locations where the name of the surgery is specified. **If the method of sterilization does not match the Consent to Sterilization and Physician's Statement sections, attach medical records documenting the difference between the planned procedure and the performed procedure to the claim for review by South Dakota Medicaid.**
- Recipient's signature.
- Month, day and year the recipient signed the form.

## *INTERPRETER'S STATEMENT*

This section must be completed when the recipient requires the services of an interpreter:

- The recipient's native language.
- Signature of the interpreter and the date the information was provided.

## *STATEMENT OF PERSON OBTAINING CONSENT*

**All fields in this section must be completed at the time of recipient signature.**

- Name of the individual requesting the sterilization.
- Name of the surgery to be performed. This must match the name of the surgery previously specified.
- Signature of the person obtaining the consent and witnessing the recipient's signature and the date consent was obtained (the date should be the same as #8).
- Name of the facility or agency the individual represents.
- Mailing address of the facility or agency.

## *PHYSICIAN'S STATEMENT*

- Name of recipient.
- Date of surgery. The surgery must take place 30 days or more after the recipient signs the form.
- Name of surgery performed. This must match the name of the surgery previously specified. **If the method of sterilization does not match the Consent to Sterilization and Physician's Statement sections, attach medical records documenting the difference between the planned procedure and the performed procedure to the claim for review by South Dakota Medicaid.**
- Signature of physician who performed the surgery.
- Date of physician's signature. This document may only be signed after the surgery is completed.

*NOTE:* The completed consent form must be attached to all sterilization claims submitted to South Dakota Medicaid.