Form Approved: OMB No. 0937-0166
Expiration date: 12/31/2018

CONSENT FOR STERILIZATION

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

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from ______________________ (*Doctor or Clinic*). When I first asked for the 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 Temporary Assistance for Needy Families (TANF) 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 ______________________ (*Specify Type of Operation*). 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 30 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: ______________ (*Date*)

I, ______________________, hereby consent of my own free will to be sterilized by ______________________ (*Doctor or Clinic*) by a method called ______________________ (*Specify Type of Operation*). 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 and Human Services, 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.

______________________ ______________
Signature *Date*

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

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ 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's Signature *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before ______________________ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation ______________________ (*Specify Type of 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 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 consequences of the procedure.

______________________ ______________
Signature of Person Obtaining Consent *Date*

____
Facility

____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon ______________________ (*Name of Individual*) on ______________ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation ______________________ (*Specify Type of 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 at 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 paragraph**: 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 30 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's Signature *Date*

MAP-251
(Rev. 10/2010)

Commonwealth of Kentucky
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services

HYSTERECTOMY CONSENT FORM

Medicaid Recipient Name ______________________________ Medicaid ID # ______________

Physician's Name ______________________________ Date of Hysterectomy ______________

>>>>COMPLETE ONLY ONE OF THE REMAINING SECTIONS & COMPLETE ALL BLANKS IN SECTION<<<<

SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECIEPT PRIOR TO HYSTERECTOMY

I HAVE BEEN INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF REPRODUCING.

____
PATIENT'S SIGNATURE DATE

____
WITNESS' SIGNATURE DATE

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW IS APPLICABLE. CHECK ONLY ONE SELECTION.

I certify that before I performed the hysterectomy procedure on the recipient listed below:

1 [ ] I informed her that this operation would make her permanently incapable of reproducing. (**This certification for retroactively eligible recipient only** – a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made.)

2 [ ] She was already sterile due to ______________________________

____
CAUSE OF STERLITY

3 [ ] She had a hysterectomy performed because of a life-threatening situation due to ______________________________

____
DESCRIBE EMERGENCY SITUATION

And the information concerning sterility could not be given prior to the hysterectomy. Life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgement agreement.

____
PHYSICIAN'S SIGNATURE DATE

SECTION C: COMPLETE THIS SECTION FOR MENTALLY-INCOMPETENT RECIPIENT ONLY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on the above recipient, it will render her permanently incapable of reproducing.

______________________________ ______________________________
WITNESS' SIGNATURE DATE PATIENT REPRESENTATIVE SIGNATURE DATE

PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above recipient was medically necessary due to ______________________________

____
REASON FOR HYSTERECTOMY

And was not done for sterilization purposes, and that to the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent. Before I performed the hysterectomy on her I counseled her representative, orally and in writing that the hysterectomy would render that individual permanently incapable of reproducing; and the individual's representative has signed a written acknowledgement of receipt of the foregoing information.

____
PHYSICIAN'S SIGNATURE DATE

Ohio Department of Medicaid

ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

Instructions: Complete Section I and either Section II or Section III.

Section I: Patient Information *(REQUIRED: Please type or print clearly)*

1	Patient's Name		
2	Name of Patient's Representative *(if any)*		
3	Patient's 12 Digit **Medicaid** Number	4	Date of Hysterectomy

Section II: Provision of hysterectomy information prior to hysterectomy procedure(s)

Patient acknowledgment of receipt of hysterectomy information:

I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is medically necessary and will not be/has not been performed solely for the purpose of making me incapable of reproducing (sterile).

Prior to the hysterectomy, I have been/was informed, both orally and in writing that the hysterectomy would make me permanently incapable of reproducing (sterile).

5	Patient/Representative Signature	6	Date of Signature

Provider acknowledgment of provision of hysterectomy information:

Prior to the hysterectomy, I informed this patient *(and her authorized representative, if applicable)* both orally and in writing, that the hysterectomy would make her permanently incapable of reproducing (sterile).

7	Name of Person Providing Information	8	Signature of Person Providing Information	9	Date of Signature

Section III: Physician certification of reason for not providing hysterectomy information prior to the hysterectomy procedure.

Prior to the hysterectomy, the patient was not informed that the hysterectomy would make her permanently incapable of reproducing (sterile) because: *(check all that apply, please type or print clearly, do not provide additional attachments)*

10 ☐ She was already sterile before the hysterectomy *(please briefly explain cause of the sterility)*:

11 ☐ The hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible *(please describe the nature of the emergency)*:

12	Name of the physician who performed the hysterectomy *(please type or print clearly)*		
13	Signature of the physician who performed the hysterectomy	14	Date of Signature

FOR REIMBURSEMENT, EACH PROVIDER MUST INCLUDE A COPY OF THIS COMPLETED FORM WITH CLAIM FOR SERVICES

Distribution: One copy to patient, one copy retained by facility; one copy retained by physician; one copy retained by anesthesiologist.

Ohio Department of Medicaid

INSTRUCTIONS FOR COMPLETING ODM 03199, ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION

In accordance with Title 42 Code of Federal Regulations (CFR) 441.251 and rule 5160-21-02.2 of the Ohio Administrative Code (OAC), for hysterectomy (surgical removal of the uterus) that is not performed for the sole purpose of sterilization, Medicaid payment may be made only when acknowledgment form ODM 03199 is completed and submitted. The form is available on the Ohio Department of Medicaid website, http://www.medicaid.ohio.gov.

All information entered on the acknowledgment form must be legible. Failure to submit a complete and legible form may delay payment or result in denial of the claim.

Section I must be completed for every patient.	
SECTION I: PATIENT INFORMATION	
1	**Patient's Name** This field shows the individual's legal name. The full surname (i.e., family name or "last" name) must be listed. An Initial may be used for the given name ("first" name) or a middle name, but the entire name must match the name on the claim.
2	**Name of Patient's Representative *(if any)*** *"Authorized representative" means a person, who is at least eighteen years old, or a legal entity who stands in place of the individual. Actions or failures of an authorized representative will be accepted as the action or failure of the individual. If an individual has designated an authorized representative, all references to "individual" in regard to an individual's responsibilities include the individual's authorized representative.* —from OAC rule 5160:1-1-01
3	**Patient's 12 Digit Medicaid Number** This number is also referred to as the "Medicaid billing number," the "recipient ID number," or the "MMIS number." It must match the number on the claim.
4	**Date of Hysterectomy** This date must match the date of service on the claim.

Either Section II or Section III must be completed.

SECTION II: PROVISION OF HYSTERECTOMY INFORMATION PRIOR TO HYSTERECTOMY PROCEDURE(S)	
5	**Patient/Representative Signature** The mark entered in this field must be the legal signature of the individual identified in Field 1 or 2.
6	**Date of [Patient/Representative] Signature** This date (month, day, and year) can be no earlier than the individual's 21st birthday.
7	**Name of Person Providing Information** This field shows the name of the doctor or clinic staff member who informed the patient, both orally and in writing, that the procedure would make her incapable of reproducing (sterile).

8	**Signature of Person Providing Information** The mark entered in this field must be the legal signature of the individual identified in Field 7.
9	**Date of Signature [of the Person Providing Information]** This date (month, day, and year) corresponds to the signature in Field 8.

SECTION III: PHYSICIAN CERTIFICATION OF REASON FOR NOT PROVIDING HYSTERECTOMY INFORMATION PRIOR TO PROCEDURE	
10	**[Option A: The individual was already sterile.]** If this option applies, indicate a reason and a brief explanation of the cause of sterility must be given.
11	**[Option B: The procedure was performed in an emergency in which provision of information was not possible.]** If this option applies, indicate a reason and a brief description of the emergency must be given.
12	**Name of the Physician Who Performed the Hysterectomy** An Initial may be used for the given name ("first" name) or a middle name, but the entire name must match the name on the claim.
13	**Signature of the Physician Who Performed the Hysterectomy** The mark entered in this field must be the legal signature of the individual identified in Field 12.
14	**Date of [Physician's] Signature** This date (month, day, and year) corresponds to the signature in Field 13 and must not be earlier than the date on which the hysterectomy was performed.