MEDICARE PLATINO 2021

APPENDIX O (21)
CERTIFICATION CONSENT FOR
STERILIZATION



Form Approved: OMB No. 0937-0166 Expiration date: 4/30/2022

STRACION

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	STATEMENT OF PERSON OBTAINING CONSENT
I have asked for and received information about sterilization from	Before signed the
. When I first asked	Name of Individual
Doctor or Clinic	consent form, I explained to him/her the nature of sterilization operation
for the information, I was told that the decision to be sterilized is com-	, the fact that it is
pletely up to me. I was told that I could decide not to be sterilized. If I de-	Specify Type of Operation
cide not to be sterilized, my decision will not affect my right to future care	intended to be a final and irreversible procedure and the discomforts, risks
or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF)	and benefits associated with it. I counseled the individual to be sterilized that alternative methods of
or Medicaid that I am now getting or for which I may become eligible.	birth control are available which are temporary. I explained that steriliza-
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED	tion is different because it is permanent. I informed the individual to be
PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO	sterilized that his/her consent can be withdrawn at any time and that
NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER	he/she will not lose any health services or any benefits provided by
CHILDREN.	Federal funds,
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	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
a child in the future. I have rejected these alternatives and chosen to be	and voluntarily requested to be sterilized and appears to understand the
sterilized.	nature and consequences of the procedure.
I understand that I will be sterilized by an operation known as a	
. The discomforts, risks	Signature of Person Obtaining Consent
Specify Type of Operation	Signature of Person Obtaining Consent
and benefits associated with the operation have been explained to me. All	
my questions have been answered to my satisfaction.	Facility Scottinto Núrce
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	Address
and that my decision at any time not to be sterilized will not result in the	1 (9)
withholding of any benefits or medical services provided by federally	PHYSICIAN'S STATEMENT
funded programs.	Shortly before I performed a sterilization operation upon
I am at least 21 years of age and was born on:	on \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
Date	Name of Individual Date of Standarding
I,, hereby consent of my own	I explained to him/her the nature of the sterilization operation
free will to be sterilized by	, the fact that it is
Doctor or Clinic	Specify Type of Operation
by a method called My	intended to be a final and irreversible procedure and the discomforts, risks
Specify Type of Operation	and benefits associated with it.
consent expires 180 days from the date of my signature below.	I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that steriliza-
I also consent to the release of this form and other medical records	tion is different because it is permanent.
about the operation to: Representatives of the Department of Health and Human Services,	I informed the individual to be sterilized that his/her consent can
or Employees of programs or projects funded by the Department	be withdrawn at any time and that he/she will not lose any health services
but only for determining if Federal laws were observed.	or benefits provided by Federal funds.
I have received a copy of this form.	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
Deta	nature and consequences of the procedure.
Signature Date	(Instructions for use of alternative final paragraph: Use the first
You are requested to supply the following information, but it is not re-	paragraph below except in the case of premature delivery or emergency
quired: (Ethnicity and Race Designation) (please check) Ethnicity: Race (mark one or more):	abdominal surgery where the sterilization is performed less than 30 days
Hispanic or Latino American Indian or Alaska Native	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 para-
Not Hispanic or Latino Asian	graph which is not used.)
Black or African American	(1) At least 30 days have passed between the date of the individual's
☐ Native Hawaiian or Other Pacific Islander	signature on this consent form and the date the sterilization was
☐ White	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
■ INTERPRETER'S STATEMENT ■	because of the following circumstances (check applicable box and fill in
If an interpreter is provided to assist the individual to be sterilized:	information requested):
I have translated the information and advice presented orally to the in-	☐ Premature delivery
dividual to be sterilized by the person obtaining this consent. I have also	Individual's expected date of delivery:
read him/her the consent form in	Emergency abdominal surgery (describe circumstances):
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	Physician's Signature Date

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations. [43 FR 52165, Nov. 8, 1978, as amended at 58 FR 33343, June 17, 1993; 68 FR 12308, Mar. 14, 2003]

J. Goins

