Form Approved: OMB No. 0937-0166

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

1 _____ . When I first asked
Doctor or Clinic

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

2 _____ . The discomforts, risks
Specify Type of Operation

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 3 _____
Date

I, 4 _____, 5 _____, hereby consent of my own
Doctor or Clinic

free will to be sterilized by

6 _____ . My
Specify Type of Operation

by a method called

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.

7 _____ 8 _____
Signature *Date*

9 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 10 _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

11 _____ 12 _____
Interpreter's Signature *Date*

HHS-687 (10/12)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before 13 _____ signed the
Name of Individual

14 _____ 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.

15 _____ 16 _____
Signature of Person Obtaining Consent *Date*

17 _____
Facility

18 _____
Address

■ PHYSICIAN'S STATEMENT ■

I performed a sterilization operation

19 _____ on 20 _____
Name of Individual *Date of Sterilization*

21 _____ 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.

22 (**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 _____ 23
- ☐ Emergency abdominal surgery *(describe circumstances)*

24 _____ 25 _____
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]

MaineCare Sterilization Consent Form Instructions

Data fields must be legible or the claim will be denied

Section 1: Consent to Sterilize

1. Provider or Clinic
    - List the name of the provider or the name of the clinic that is providing information to the patient about sterilization
    - The name may be different from the physician performing the procedure

    Examples of Provider names in acceptable format:
    Dr. Jane Doe, MD or Jane Doe, OB/GYN, or Jane Doe, FNP

    Examples of Clinic names in acceptable format:
    The West End Medical Clinic or Our Family Practice

2. The name of the procedure discussed with the patient
    - The same procedure should be listed in fields 6, 14, and 21

3. Patient's Date of Birth

4. Patient's name

5. Name of Doctor or Clinic
    - List the doctor or clinic selected to perform the procedure
    - The name does not have to be the same as field 23

6. Procedure name discussed with the patient
    - The same procedure should be listed in fields 2, 14, and 21

7. Patient's signature
    - Patient must be 21 at date of signing

8. The date the patient is signing the consent form

9. Ethnicity designation (optional)

Section 2: Interpreter's Statement

This section only needs to be filled out if an interpreter was used to communicate with the patient.

10. Identify the language used to communicate with the patient

11. The name of the interpreter

12. The date the interpreter provided services

Section 3: Statement of Person Obtaining Consent

13. Patient's name

14. Procedure name discussed with the patient
    - The same procedure should be listed in fields 2, 6, and 21

15. The signature of the individual obtaining the consent

16. The date the individual obtained the consent
    - The date of consent needs to match line 8
    - If the selected physician or clinic, as indicated in field 5, is obtaining the consent and has signed on field 15, then the date can either match line 8 or be later than line 8

17. The name of the facility where consent was obtained

18. The address of the facility where consent was obtained
    - List the **physical address** of the facility
    - Include the street number and name, (Suite number), town, state, and zip code
    - All elements must be present or form will be rejected
    - No PO Boxes accepted
    - Suite number when necessary for identification

Section 4: Physician's Statement

19. Patient's name

20. The date of the procedure
    - Must be more than 30 days from the date patient signed in field 8, but no greater than 180 days

    Example: Patient signs the consent form 7/16/2014; consent is valid from 8/15/2014 to 1/12/2015.

21. Name of procedure being performed
    - The same procedure should be listed in all required fields 2, 6 and 14

22. Instructions for use of alternative final paragraph selection (1 or 2)
Cross out the paragraph which is not used, if not, claim will be denied. If (1) is crossed out, field 23 must be completed or form will be rejected.

23. Check the appropriate box
    - Enter the expected date of delivery or the premature delivery date
    - Additional space available to describe the emergency service when necessary

24. Physician's signature that performed the procedure

25. The date the performing physician signs the consent form
    - Must be on, or after, the date of surgery
    - The form will be rejected if not dated correctly