

Money Follows the Person Demonstration Cover Page
(to be completed by county waiver agency and submitted with care plan)

County/Agency _____

Care Manager/Support and Service Coordinator _____

Participant Name _____

Medicaid ID _____ Birth date _____

Name of Institution _____

Length of Time in Institution _____

Planned Community Living Arrangement (Check one)

- House Owned or Leased by Participant
- House Owned or Leased by Participant's Family
- Apartment leased by Participant
- Apartment leased by Participant's Family
- Supported Apartment leased by Provider
- 1-2 Bed Adult Family Home
- 3-4 Bed Adult Family Home

Checklist

- Informed Consent Form (DDE 941 or DDE 941A) Completed and Copy Submitted to Department by mail or fax (original should be kept in participant file)
 - Form 941 should be used in counties in which the participant **will not be** transitioned to Family Care during the 12-month MFP participation period.
 - Form 941a should be used in counties in which the participant **will be** transitioned to Family Care during the 12-month MFP participation period.
- Emergency Contact Information Provided to Participant

Provide name of person who will conduct Pre-Relocation Quality of Life (QoL) Survey and submit to Department (to be completed after agreement to participate, but before move).

For CIP 1A and CIP 1B - _____
CIS or state central office staff from the Department

For CIP II or COR - _____
County care manager or other county designee