

### MONEY FOLLOWS THE PERSON (MFP) – PARTICIPANT REPORTING

For use by Family Care, Family Care Partnership, PACE MCOs, Medicaid Waiver Agencies and IRIS

Completion of this form is voluntary. Failure to complete this form may result in delayed processing of the MFP referral.

#### MFP PARTICIPANT INFORMATION

**Check One Box**

- Planned Transition Date \_\_\_\_\_  
 Confirmed Transition Date \_\_\_\_\_ →If confirmed, lives with family member?  Yes  No

Name – Participant		Birth Date
Medicaid ID	Target Group	Institution Admission Date
Facility Name (If Applicable)	Address (Street, City, Zip)	Phone Number ( )

Community Living Arrangement (After checking appropriate box list address and phone in space provided below if known)

- Home owned by participant  
 Home owned by family member  
 Apartment / house leased by participant or participant's family  
 1- to 4-bed adult family home  
 Residential Care Apartment Complex *Name* \_\_\_\_\_  
 CBRF *Name* \_\_\_\_\_  
 Nursing Home *Name* \_\_\_\_\_

Address (Street, City, Zip)  Phone Number ( )
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#### GUARDIAN OR LEGAL DECISION MAKER INFORMATION

Guardian Name	Guardian Phone Number		
Guardian Street Address	City	State	Zip

#### AGENCY INFORMATION

Name – Agency	Name – Agency Contact (Type or Print)		
Phone Number ( )	Email Address	Date	

**SEND FORM BY FAX TO 608-221-6594**

#### MFP OFFICE USE ONLY

**Pre-Transition**

- MFP Eligible Survey Date: \_\_\_\_\_ Assigned to Name: \_\_\_\_\_  
 MFP Ineligible Reason: \_\_\_\_\_

**Confirmed - Transition**

- MFP Eligible Date entered into MMIS Interchange: \_\_\_\_\_ Date entered into MFP database: \_\_\_\_\_  
 MFP Ineligible Reason: \_\_\_\_\_