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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-00334 (03/2017) | | | | | | | | | |  | | | | | | | **STATE OF WISCONSIN** | | | | | |
| **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 | | | | | | | | | | | | | Address (Street, City, Zip) | | | | | | | | | |
| Home owned by family member | | | | | | | | | | | | |  | | | | | | | | | |
| Apartment / house leased by participant or participant’s family | | | | | | | | | | | | |  | | | | | | | | | |
| 1- to 4-bed adult family home | | | | | | | | | | | | | Phone Number (     ) | | | | | | | | | |
| Residential Care Apartment Complex | | | | | | | | *Name* | | | | | | | | | | | | | | |
| CBRF | *Name* | | | | | | | | | | | | | | | | | | | | | |
| Nursing Home | | | *Name* | | | | | | | | | | | | | | | | | | | |
| **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: | | | | | |  | | | | | | | |
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| MFP Ineligible | | Reason: | |  | | | | | | | | | | | | | | | | | | |
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| **Confirmed - Transition** | | | | | | | | | | | | | | | | | | | | | | |
| MFP Eligible | | Date entered into MMIS Interchange: | | | | | | |  | | | | | Date entered into MFP database: | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| MFP Ineligible | | Reason: | |  | | | | | | | | | | | | | | | | | | |