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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-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: |       |
|  |
| [ ]  MFP Ineligible | Reason: |       |
|  |  |
| **Confirmed - Transition** |
| [ ]  MFP Eligible | Date entered into MMIS Interchange: |       | Date entered into MFP database: |       |
|  |
| [ ]  MFP Ineligible | Reason: |       |