DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Medicaid Services
F-00334 (03/2017)

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 ( )

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: _____

DISTRIBUTION: Original to MCO, IRIS, or County Waiver Agency; Copy to MFP