# North Carolina's Money Follows the Person Application Form

Today's Date: _____

| 1. Participant Information | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Name: | | | | SS #: | | | | | |
| DOB: | | Medicaid #: | | | Medicare #: | | | | |
| If applicable, what was final day of Medicare rehab payment? | | | | | | | | | |
| Is client financially eligible for CAP waiver services? | | | ☐ Yes ☐ No | | | | | | |
| Street Address: | | | | | | | | | |
| City: | | County: | | State: | NC | Zip: | | | |
| Medicaid County: | | County moving to: | | | | | | | |
| Phone #: | | Alternate Phone #: | | | | | | | |
| Will applicant have a Medicaid deductible upon transitioning? | ☐ Yes ☐ No ☐ Don't Know | | | | | | | | |

| 2. Person or Agency Making Referral | | | | | | |
|---|---|---|---|---|---|---|
| Name/Agency(if Applicable): | | | | | | |
| Email address: | | | | | | |
| Street Address: | | | | | | |
| City: | | County: | | State: | NC | Zip: |
| Phone #: | | Fax #: | | | | |

| 3. Responsible Party (i.e., Guardian, closest family member) | | | | | | |
|---|---|---|---|---|---|---|
| Name: | | | | | | |
| Street Address: | | | | | | |
| City: | | County: | | State: | NC | Zip: |
| Phone #: | | Alternate Phone #: | | | | |
| Email address: | | | | | | |
| Relationship to Client: | | | | | | |

| 4. LME/Lead Agency Information (if different from above) | | | | | | |
|---|---|---|---|---|---|---|
| Agency Contact: | | | | | | |
| Email address: | | | | | | |
| Street Address: | | | | | | |
| City: | | County: | | State: | NC | Zip: |
| Phone #: | | Fax #: | | | | |

**Please fill all fields to the best of your ability for a prompt response.**
Email this completed form to diane.upshaw@dhhs.nc.gov or fax to 919-715-4159.

| 5. Institution/Facility Information *(where participant currently lives)* | | | | | | | |
|---|---|---|---|---|---|---|---|
| Facility Name: | | | | | | | |
| Existing Funding Source: | □ ICF/MR □ ICF □ Skilled Nursing | | | | | | |
| Street Address: | | | | | | | |
| Mailing address, if different: | | | | | | | |
| City: | | County: | | State: | NC | Zip: | |
| Contact Person's Name: | | | | | | | |
| Phone #: | | Fax #: | | | | | |
| Email address: | | | | | | | |
| How long has participant lived here? (mm/yr – mm/yr) | | | | | | | |
| Current FL-2 level of care (if applicable): | | | | | | | |

| 6. Preferred Living Arrangements | | |
|---|---|---|
| Anticipated Transition Date (if known): | | |
| Type | Check one | Comments |
| With relatives/caregiver in apartment | | |
| With relatives/caregiver in home | | |
| Alone in apartment | | |
| Alone in own home | | |
| In 4-bed or less group home (4 unrelated individuals) | | |

After completing this form, the MFP Informed Consent form and the Video Release form, email (password protected) or fax all forms to MFP staff at DMA Raleigh office.

**Important facts to remember:**

- There is no CAP wait list for clients who are MFP eligible
- You must submit the MFP Informed Consent Form with this Application Form
- Facilities are considered partners in the transition process and will receive a copy of approved application form and will participate in the transition process
- There will be an additional page to complete if the client is given, and accepts, a waiver slot

| 7. MFP staff use only | | | |
|---|---|---|---|
| Eligibility Criteria | Check One | | Comments |
| Meets qualified institution/facility | □ Yes □ No | | |
| In institution/facility at least 3 months | □ Yes □ No | | |
| Meets qualified residence | □ Yes □ No | | |
| Medicaid eligible | □ Yes □ No | | |
| Transition Coordination Agency: | | | |
| Authorized by: | | | |
| Title: | MFP Project Director | Date: | |