North Carolina Money Follows the Person Project

Application for Participation

May 2021 ed.

Required Information on MFP Applicant: If We Don't Have It, We Can't Process the Application		
Today's Date		
Applicant's Name (Last)	**First**	**Middle Initial**
Social Security Number	**Applicant's Date of Birth**	**Gender** ☐ **M** ☐ **F**
Medicaid Number	**Medicare Number**	**Applicant's Phone Number**
Has the applicant previously participated in MFP? ☐ Yes ☐ No Note: Participation in MFP is limited to 3 instances of application approval.		
Type of Facility: ☐ Skilled Nursing Facility ☐ Intermediate Care Facility for People with Intellectual Disabilities ☐ Acute Care Hospital ☐ Psychiatric Residential Treatment Facility ☐ Other (list here):		
Name of Facility	**Street Address**	
City	**State** / **Zip** / **County**	
Facility Social Worker/Point of Contact Name	**Phone** / **Fax**	
	Email	
Date of admission to this facility	**Was applicant admitted from hospital?** ☐ Yes ☐ No	
	If Yes, hospital admit date	**Hospital discharge date**
Was applicant admitted under Medicare Part A Rehab? ☐ Yes ☐ No	**If yes, last day of rehab (or last anticipated day)**	

Has the applicant had other stays in a Long-Term Care facility in the past year?

(This includes skilled nursing centers, rehab centers, hospitals, intermediate care facilities, psychiatric residential treatment facilities, and state psychiatric hospitals)

☐ Yes ☐ No

Stay 1	**Facility Name**		**Street Address**	
	City	**State**	**Zip**	**Phone**
	Admission Date		**Discharge Date**	
Stay 2	**Facility Name**		**Street Address**	
	City	**State**	**Zip**	**Phone**
	Admission Date		**Discharge Date**	
Stay 3	**Facility Name**		**Street Address**	
	City	**State**	**Zip**	**Phone**
	Admission Date		**Discharge Date**	

Helpful Information: **Having this Information Will Keep the Process Moving as Quickly as Possible**		
Does the applicant have a mental health diagnosis? ☐ Yes ☐ No **Specify:**		
Does the applicant have a drug and/or alcohol diagnosis? ☐ Yes ☐ No **Specify:**		
Does the applicant have a developmental disability diagnosis? ☐ Yes ☐ No **Specify:**		
If yes to any diagnosis, is the applicant receiving treatment or services? ☐ Yes ☐ No **Specify:**		
Primary Family Member(s) or Other Point(s) of Contact		
Name:	**Phone Number:**	**Type of Authority:** ☐ Family/Friend—no legal responsibility for applicant ☐ Family/Friend—Guardian ☐ Family/Friend—Power of Attorney ☐ Family/Friend-Legal Status Unknown ☐ Organizational Guardian
Does this person assume decision-making authority for this applicant? Yes ☐ No ☐ Unknown ☐		
Name:	**Phone Number:**	**Type of Authority:** ☐ Family/Friend—no legal responsibility for applicant ☐ Family/Friend—Guardian ☐ Family/Friend—Power of Attorney ☐ Family/Friend-Legal Status Unknown ☐ Organizational Guardian
Does this person assume decision-making authority for this applicant? Yes ☐ No ☐ Unknown ☐		

Completing the Application		
Name of Person Completing/Assisting with Application:		
Organization Name (if applicable):		
Phone:	**Fax:**	**Email:**

Affiliation (check one):

- ☐ Self, No Help
- ☐ Local Contact Agency
- ☐ Facility Listed Above
- ☐ MCO
- ☐ CAP DA Lead Agency
- ☐ Area Agency on Aging
- ☐ Other (please list):
- ☐ Family, Friend or Corporate Guardian
- ☐ Center for Independent Living
- ☐ Private Medicaid Provider
- ☐ DVR-IL
- ☐ Civic/Advocacy Group Not Otherwise
- ☐ PACE

About Me: My Community-Based Living Support Needs and Interests	
Income	
Does the applicant have income? ☐ Yes ☐ No	
Monthly Income: ☐ **SSI:** ☐ **SSDI:** **Total Estimated Monthly Income:**	☐ **Veteran's Benefits:** ☐ **Other (specify):**
Housing	
Type of Housing preferred (check one):	
☐ My own home/apartment ☐ My family's home/apartment	☐ Group home of four people or less (Individuals with Intellectual Disabilities only) ☐ Alternative Family Living/ "AFL" (Individuals with Intellectual Disabilities only)
Do you currently have a home outside the facility? ☐ Yes ☐ No	
If you have housing, list home/apartment address:	
Do you need assistance with finding housing? ☐ Yes ☐ No	
Required: If you don't have housing, what county do you prefer to live in? (no response may cause delay in processing):	
Desired Transition Date:	

About Me: My Community-Based Living Support Needs and Interests		
This section is voluntary, but will help us direct your application to the right transition team and make sure your application meets with Project requirements		
When you move to the community, please list family, friends, and others from religious and civic groups that may be *willing to assist with hands-on care or backup support*. Civic groups may include Red Hat, Lion's Club, Rotary Club, book clubs, Sororities/Fraternities, etc.		
Name:	**Relationship/Affiliation:**	**Phone Number/Other Means of Contact:**

About Me: My Community-Based Living Support Needs and Interests				
Activity (Please check boxes that apply)	**I Need A Lot of Support** (I use a wheelchair or need hands-on assistance, people to be nearby most of the time)	**I Need Some Support** (I may need some help with some of these tasks, but not all of them; I need support sometimes but not all of the time)	**I Don't Need Any Support—I can do it myself.**	**Notes**
Moving around	☐	☐	☐	
Getting out of bed or chair	☐	☐	☐	
Bathing, dressing, taking care my bathroom needs	☐	☐	☐	
Eating	☐	☐	☐	
Meal preparation	☐	☐	☐	
Home maintenance, laundry	☐	☐	☐	
Daily decision making	☐	☐	☐	

Who provided the information to complete this section? (Check One)

☐ MFP applicant directly (even if someone else needed to physically write)

☐ A family member, guardian or other support to the applicant

☐ Facility staff

☐ Other (list here):

Complete this form as well as the MFP Informed Consent Forms and fax all forms to 919-882-1664 or email (password protected) to mfpinfo@dhhs.nc.gov

MFP Staff Use Only		
Medicaid County:	Facility Type Listed in NC FAST:	Income from NC FAST:
Meets qualified institution/facility ☐ Yes ☐ No	Meets qualified residence ☐ Yes ☐ No	
In institution/facility at least 60 days ☐ Yes ☐ No	Medicaid eligible ☐ Yes ☐ No	
Transition Coordination Agency:		
Authorized By *(Print name)* _____ *(Signature)* _____ (*Date)* _____		

NC MFP Informed Consent and Authorization to Share Information

Hello!

We are so glad that the North Carolina Money Follows the Person Demonstration Project (NC MFP) may be able to assist you in returning to your home and community. Thank you for taking the time to read this information. We want to make sure you have a clear understanding of the NC MFP Project and its transition process. **We know there is a lot of information here, so please don't hesitate to ask questions and get assistance. We're happy to help.**

Thanks for Your Interest in NC MFP!
The NC MFP Staff
1-855-761-9030

To Complete this Form, Think "Inside the Box"

☑

Throughout this document there are places to check a box. By checking the box, you are showing that you have read and understand the material in that section of the Informed Consent Form.

Who Qualifies for NC MFP

Money Follows the Person (MFP) is a demonstration project that assists individuals in North Carolina to move from qualified institutions back into their own communities. To be eligible for MFP, a person must meet the following requirements:

1. Currently reside in an institution for intellectual and/or developmental disabilities (private or state-operated ICF-IID facility) or currently placed at a skilled nursing facility for two months or longer.
   a) Be eligible for Medicaid prior to transitioning back into the community.
2. Move into a qualified community residence which includes one the following:
   a) A home owned or leased by the individual or the individual's family member.
   b) An apartment with a monthly lease including lockable access along with living, sleeping, bathing, and cooking areas which the individual or their family have domain over.
   c) A residence in a community-based setting with no more than four unrelated individuals reside.

3. Meet the eligibility requirements/criteria of the waiver or PACE program that s/he intends on using upon transition.

REALLY IMPORTANT: MFP approval doesn't automatically mean you have a waiver slot. While MFP participants have priority status for MFP-reserved waiver slots, it's important to know that 1) there must still be MFP waiver slots available that waiver year, AND 2) you must also meet the waiver-specific requirements before a waiver slot can assigned to you.

☐ **YES, I have read this section and understand what it means.**

Your Responsibilities in the Transition Process

Important Information about Discharging from the Facility and MFP Enrollment:

It's important that you coordinate your discharge date with your MFP transition team. If you discharge to the community without having an approved MFP application, without MFP staff knowledge, and enrollment in a waiver service **you may lose your MFP status**. This means you will not be eligible for MFP's "startup" funds or have priority status for waiver services.

☐ **YES, I understand that I may not be eligible for MFP services if I discharge without coordinating with MFP staff.**

The success of a transition relies on collaborative work by the participant, family, guardian, friends, community-based programs, case manager, transition coordinator, and MFP staff.

- To the extent possible, the MFP participant will guide his/her own transition process and assume responsibilities in ensuring the transition occurs (i.e. calling possible housing options, identifying a bank, etc.)
- Along with their families, as appropriate, MFP participants agree to help develop their Transition Plan, including goals designed to make community-based living reasonable and accessible resources outlined.
- Along with their families, as appropriate, work with the entities that are making community-based living an option by achieving set goals within set time frames (like not cancelling meetings at the last minute, following up on my "to do list" as appropriate, returning calls promptly, etc.)

☐ **YES, I have read this Section and agree to do my part to make sure my transition is organized and well-planned.**

Transition Year Stability Resource Funding

- Depending on the community services you need, NC MFP participants may have access to up to $3,000.00 of "startup" funds to help cover the cost of the one-time expenses associated with transitioning that cannot be accommodated in the waiver budget. This amount is subject to change at any time.

- Examples include: pre-transition staff training, housing and utility deposits, deposits on personal emergency response systems, home modifications and household supplies.
- These funds are ONLY available up to 365 days AFTER you transition.
- Funding requests are submitted by the Transition Coordination Agency and must be authorized by MFP staff.
- Funds cannot be used for cigarettes, alcohol, electronics for entertainment purposes, or ongoing living expenses.

☐ **YES, I have read this Section and understand the "basics" of the Transition Year Stability Resource Fund**

Continuation of Care

Upon the 365th day of participating in the MFP Demonstration Project, you may continue with wavier services if you continue to meet the wavier program's level of care and other requirements.

☐ **YES, I understand that if my circumstances don't change, my services should continue after my MFP participation ends.**

Pre-Transition Dis-Enrollment and Re-Enrollment

Important Information about Why a Participant May be Dis-Enrolled Before Transitioning

NC MFP is going to work hard to help you get home. Our transition coordinators are passionate about what they do and want to support your transition. However, it's important to know that NC MFP may dis-enroll an MFP Participant from the Program prior to transitioning for the following reasons:

1. MFP participant does not meet the criteria for the applicable program (e.g. CAP DA, PACE, Innovations, etc.).
2. MFP participant is unable or unwilling to move into a "qualified residence" that is both authorized under federal law and supported by the applicable NC waiver program.
3. MFP participant does not honor transition-related commitments as outlined in the NC MFP Informed Consent document. Participant refuses to comply with agreements as outlined in the Informed Consent, Transition Plan of Care or Risk Mitigation agreements

NC MFP reserves the right to dis-enroll an MFP participant who has not yet transitioned at any time for the reasons outlined above. If after six months from the day of the first transition meeting, the transition coordinator determines that the participant does not yet meet the applicable waiver program requirements or have acceptable housing identified, the transition coordinator may also recommend dis-enrollment so long as the decision is supported by MFP leadership staff.

When MFP elects to dis-enroll an MFP participant, the participant has a right to appeal the decision and will receive guidance on doing so. Appeal rights for Innovations, CAP DA/CHOICE and PACE are managed according to the guidelines of the specific program.

☐ **YES, I understand the reasons why NC MFP may dis-enroll me prior to transition and that I would have the right to challenge that decision through the Medicaid program's appeals process.**

Reiterating Important Information about Discharging from the Facility and MFP Enrollment:

It's important that you coordinate your discharge and discharge date with your MFP transition team. If you discharge to the community without having an approved MFP application, without MFP staff knowledge, and enrollment in a waiver service **you may lose your MFP status**. This means you will not be eligible for MFP's "startup" funds or have priority status for waiver services.

☐ **YES, I understand that I may not be eligible for MFP services if I discharge without coordinating with MFP staff.**

Post-Transition Dis-Enrollment and Re-Enrollment

REASONS WHY A PARTICIPANT MAY BE DIS-ENROLLED AFTER TRANSITONING:

An MFP participant retains MFP participant status for one year after the participant's transition date. After 365 days, the participant is automatically dis-enrolled from the MFP Program. During this 365 day period, MFP participation can be terminated for the following reasons:

1. Participant no longer meets the criteria for the waiver program or PACE program;
2. Participant is re-institutionalized for more than 30 days;
3. Participant transitions to a residence that does not meet MFP federal criteria or does not meet applicable home and community-based program criteria;
4. Participant no longer receives Medicaid;
5. Participant refuses to comply with agreements as outlined in the Informed Consent, Transition Plan of Care or Risk Mitigation agreements; or
6. Participant no longer meets relevant level of care criteria.

☐ **YES, I understand the reasons why NC MFP may dis-enroll me after transition and that I would have the right to challenge that decision through the Medicaid program's appeals process.**

Important Information about MFP Re-Enrollment Once You Transition into the Community:

Any MFP participant that is re-institutionalized for a period longer than 30 consecutive days will be considered **dis-enrolled** from the program. However, the individual is eligible for re-enrollment without re-establishing the three month institutionalization requirements, as long as the individual meets Medicaid waiver eligibility criteria. The participant then will be eligible for MFP services at the enhanced Federal Medicaid Assistance Percentage match. Any participant having 3 incidences of re-institutionalization of 30 consecutive days or longer will not be eligible for reentry into the MFP Project.

Any former participant may re-enroll after being re-evaluated and with an updated plan of care in place. Once the individual is found eligible for community-based services the updated plan of care addressing any change in the status of the MFP participant and/or any concerns with lack of necessary community supports will be submitted to MFP staff for review. If a former participant reenters a qualified institution for 6 months or longer then the participant will be defined as a "new" MFP participant if they wish to consider transitioning again.

☐ **YES, I understand this Dis-Enrollment and Re-Enrollment Policy.**

Withdrawal

Since the MFP Demonstration Project is voluntary, a participant is able to withdraw at any point by making the request in writing to the Project at any time. If MFP elects to dis-enroll an MFP participant, the participant has a right to appeal the decision and will receive guidance on doing so. Appeal rights for Innovations, CAP DA/CHOICE and PACE are managed according to the guidelines of the specific program.

☐ **YES, I understand I can withdraw from the MFP Program at any time by letting the Project Staff know in writing.**

Complaints

MFP staff strives to be responsive to concerns and issues that you may have. We encourage you to contact us directly if you have concerns about the quality of service you are receiving regarding your transition process. We may be able to help you resolve your concerns and encourage you to call our toll-free number at: 1-855-761-9030 or email us at mfpinfo@dhhs.nc.gov. If we have not been able to resolve your concerns or you would prefer to not discuss your issue with MFP staff, the Department of Health and Human Services (DHHS) Ombudsman Program was created to address inquiries and complaints that consumers and their legal guardians have regarding services that DHHS oversees or administers. The Regional Long-Term Care Ombudsman program can also be accessed through the CARE-LINE 24 hours a day, 7 days a week, by calling 1-800-662-7030 (English or Spanish) or 1-877-452-2514 (TTY).

☐ **YES, I understand the different ways to make a complaint about the services I receive through NC MFP.**

Giving my Consent

By checking here and signing below:

☐ I am letting MFP staff know that I understand the information contained in this MFP Informed Consent document.

☐ I am letting MFP staff know that I have asked any questions I have at this point and understand I may ask additional questions at any time.

☐ I understand I can get a copy of this document any time I want one.

☐ I understand that I can change my mind about these agreements at any time but changing my mind may impact my ability to participate in the MFP Project.

☐ I understand this document is valid for one year after the date of my transition or earlier, if I decide to revoke it.

☐ **YES, I would like to become a North Carolina Money Follows the Person participant.**

SIGNATURES

_____ Name of MFP Applicant (please print)

_____Signature (or Mark) of MFP Applicant

_____Date

_____Signature of Guardian or Authorized Representative (if applicable)

_____Date

NC MFP Application: Authorization to Disclose Health Information

Please complete this document as part of your MFP Application

MFP Applicant Name _____

Date of Birth _____

MFP Applicant Medicaid Identification Number _____

To ensure a coordinated and organized transition to a new place of residence,

I _____ (MFP Applicant or Authorized Representative) hereby authorize NC Money Follows the Person Staff and Transition Coordinators to disclose my/the MFP Applicant's name, location and health information related to the transition process to the following agencies:

Description of Agency	Reason for Contacting	Notes
The facility in which you currently live (for example, the social worker and billing specialist there).	To begin transition coordination process To ensure your eligibility for this Project	
The Medicaid entity that oversees case management services in your area.	To ensure they can participate in the planning process.	Examples include: Local CAP DA Lead Agency or the "MCO."

Description of Agency	Reason for Contacting	Notes
The Division of Vocational Rehabilitation's Independent Living Office	To help coordinate the transition process (if applicable). To access supports around home modifications and assistive technology (as applicable).	This may not be necessary for every MFP participant
The local Department of Social Services (DSS) (for example, the Medicaid Representative)	To help clarify questions about your Medicaid enrollment or possible deductible status.	
The Division of Aging and Adult Services	To access supports around identifying and securing qualified housing.	This may not be necessary for every MFP participant
IMPORTANT **If you have concerns about MFP staff and transition coordinators contacting any of the entities listed above, please explain here:**		

ADDITIONAL INFORMATION ABOUT SHARING HEALTH INFORMATION AND YOUR PRIVACY

* MFP Project Staff is happy to provide additional explanation if you have any questions about information below.

By checking here and signing the following page:

☐ I understand that this authorization will expire on the following date, event or condition:

One year after I transition under MFP (or if I decide to leave the MFP program).

☐ I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign a Revocation form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

☐ I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

☐ I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

☐ I further understand that I may request a copy of this signed authorization.

Signature and Authorization

Legal Guardian (if applicable)				
Name (Last)	First		Middle Initial	
Address	City	State	Zip	Phone
Type of Guardianship: ☐ Person ☐ Estate ☐ Person and Estate				
Parent (if applicant is under the age of 18)				
Name (Last)	First		Middle Initial	
Address	City	State	Zip	Phone
Type of Guardianship: ☐ Person ☐ Estate ☐ Person and Estate				

To Complete the Application Please Sign and Date Below

Signature or Mark of Applicant	Date (mm/dd/yyyy)
Signature of Legal Guardian/Parent (if applicable)/Authorized Representative	Date (mm/dd/yyyy)

Once this form is completed please fax to

919-882-1664 or email (password protected) to mfpinfo@dhhs.nc.gov