MFP Post-Transition Withdrawal Recommendation Form

Please email (encryption only) or fax form to:

North Carolina Money Follows the Person Demonstration Project

Email: MFPInfo@dhhs.nc.gov

Fax: (919) 715-4159

Participant's Name:	
Medicaid ID Number:	
Date of Recommendation:	



Date of Recommendation:				
MFP Transition Coordinator recommends Post-Transition withdrawal due to the f	Callawing.			
Beneficiary's circumstances no longer meet criteria of applicable HCBS program;	onowing.			
□ Beneficiary no longer receives Medicaid □ No longer waiver eligible □ Beneficiary transitioned to a residence that does not meet MFP federal criteria or does not meet applicable home and community-based program criteria □ Beneficiary is reinstitutionalized for more than 30 days; Reason(s) for re-institutionalization greater than 30 days □ Acute care hospitalization followed by long-term rehabilitation □ Deterioration in cognitive function □ Deterioration in health □ Deterioration in mental health □ Loss of housing □ Loss of personal care giver □ By request of participant or guardian				
			□Lack of sufficient community services	
			□Other (please explain)	
			Beneficiary refuses to comply with agreements as outlined in the Informed Consent,	Plan of Care, or Risk Mitigation agreements
			Beneficiary no longer meets relevant level of care criteria.	
			Beneficiary no longer needs services.	
			Death Steps taken to resolve Post-Transition withdrawal recommendation:	
			Informal conversation with individual	Date:
			Informal conversation with transition coordination team	Date:
			Consultation with DVR Housing and Transition Program Specialist or MFP staff	Date:
			Other:	
Beneficiary Voluntarily Withdraws:				
(Signature)	(Date)			
Transition Coordinator:(Signature)	(Date)			
Supervisor Reviewed:(If applicable)	(Date)			
(Signature)	(Date)			
Recommendation accepted:(Designated MFP Staff Signature)	(Data)			
	(Date)			
Due Process Initiated:				

If you have questions, please contact the MFP staff at 1-855-761-9030