MONEY FOLLOWS THE PERSON
DEMONSTRATION PROJECT

North Carolina Money Follows the Person Demonstration Project
Application for Participation
May 2024 ed.

Required Information on MFP Applicant:

Please complete the entire MFP Application before submission.

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**	**Do you need a translator?** ☐ Yes ☐ No

Please check your preferred method of contact:

☐ **In-Person** ☐ **Cell Phone:** ☐ **Email:**

Has the applicant previously participated in MFP? ☐ Yes ☐ No

Note: Participation in MFP is limited to 3 instances of application approval.

Date of admission to this facility:	**Type of Facility:** ☐ Skilled Nursing Facility ☐ Acute Care Hospital ☐ Intermediate Care Facility for People with Intellectual Disabilities ☐ Psychiatric Residential Treatment Facility ☐ Other (list here):

Name of Facility	**Street Address**	
City	**State** **Zip** **County**	
Facility Social Worker/Point of Contact Name	**Email**	
	Phone	**Fax**
Was applicant admitted from hospital? Yes ☐ No ☐	**If Yes, hospital admit date**	**Hospital discharge date**

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**	

Required Information on Points of Contact:

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:	Relationship/Affiliation:	Phone Number/ Other Means of Contact:	Type of Authority:
			☐ Family/Friend—no legal responsibility for applicant ☐ Family/Friend—Guardian ☐ Family/Friend—Power of Attorney ☐ Organizational Guardian

Does this person assume decision-making authority for this applicant?
Yes ☐ No ☐ Unknown ☐

Name:	Relationship/Affiliation:	Phone Number/ Other Means of Contact:	Type of Authority:
			☐ Family/Friend—no legal responsibility for applicant ☐ Family/Friend—Guardian ☐ Family/Friend—Power of Attorney ☐ 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
- ☐ Division of Employment and Independence for People with Disabilities (EIPD)
- ☐ Civic/Advocacy Group
- ☐ PACE

About Me: My Community-Based Living Support Needs and Interests

Income

Does the applicant have income? ☐ Yes ☐ No

Monthly Income:

☐ **SSI:**

☐ **SSDI:**

☐ **Veteran's Benefits:**

☐ **Other (specify):**

Total Estimated Monthly Income:

Housing

Do you currently have a home outside the facility? ☐ Yes ☐ No

If you have a home outside the facility, list home/apartment address:

MFP does not provide housing. MFP can offer support in your housing search by linking you with income-based housing options.

If you don't have your own housing outside the facility to return to, what type of housing do you prefer?

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)

Have you applied for a housing choice voucher program (Section-8 housing)? ☐ Yes ☐ No

If so, have you received a voucher? ☐ Yes ☐ No

If not, are you interested in applying for income-based housing options? ☐ Yes ☐ No

***Please note, transition times may vary depending on housing availability and preferences.**

About Me: My Community-Based Living Support Needs and Interests

This section will help us direct your application to the right transition team and make sure your application meets with Project requirements.

Who will be your personal support system in the community?

A personal support system in the community is an individual, or group of individuals that can help you with things like transportation (*appointments, groceries, events*), meals (*delivery or cooking assistance*), emergency contact *("on-call")*, personal care (*toileting, hygienic care, or transferring from bed to chair*), etc.

Please consider including *family, friends*, and *supports* from people or groups you are connected to including faith groups, civic groups (ex: Lion's Club, Rotary Club, book clubs, Sororities/Fraternities), etc.

Name:	Relationship/Affiliation:	Phone Number/Other Means of Contact:	Type of Support: (*Transportation, Meals, Emergency, Personal Care, etc.*)

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 Authorization to Release Health Information, 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 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	This includes State Developmental Centers, Psychiatric Residential Treatment Facilities (PRTFs), Intermediate Care Facilities (ICF), Institute for Mental Disease (IMD), or the Skilled Nursing Facility (SNF).
The Medicaid entity that oversees case management services in your area.	To ensure they can participate in the planning process.	This includes the entity that oversees your HCBS: CAP/DA CME, LME/MCO, or PACE centers.

Description of Agency	Reason for Contacting	Notes
The Division of Employment and Independence for People with Disabilities (EIPD)	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	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