

North Carolina Money Follows the Person Demonstration Project Application for Participation

Required Information on MFP Applicant: Please complete the entire MFP Application before submission. Today's Date **Applicant's Name (Last)** Middle Initial First Applicant's Date of Birth Gender **Social Security Number** М **Medicaid Number Medicare Number** Do you need a translator? No Yes Please check your preferred method of contact: In-Person Cell Phone: Email: Has the applicant previously participated in MFP? No Note: Participation in MFP is limited to 3 instances of application approval. Date of admission Type of Facility: to this facility: Acute Care Hospital Skilled Nursing Facility Psychiatric Residential Intermediate Care Facility Treatment Facility for People with Intellectual Disabilities Other (list here): Name of Facility Street Address State County Zip City **Facility Social Worker/Point of Email Contact Name** Fax Phone Hospital discharge date Was applicant admitted from If Yes, hospital admit date hospital? Yes Nol

Has the applic	ant had other stays	in a Long-Term Ca	re facility in the past	year?
	killed nursing centers, rement facilities, and state		s, intermediate care faci	lities, psychiatric
Yes No	1			
Stay 1	Facility Name		Street Address	
	City	State	Zip	Phone
	Admission Date		Discharge Date	
	Facility Name		Street Address	
Stay 2	City	State	Zip	Phone
	Admission Date		Discharge Date	
	Facility Name		Street Address	
Stay 3	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? No Specify: Yes Primary Family Member(s) or Other Point(s) of Contact Name: Relationship/Affiliation: Type of Authority: Phone Number/ Other Means of Family/Friend—no legal Contact: 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 Phone Number/ Name: Relationship/Affiliation: Type of Authority: Other Means of Family/Friend—no legal Contact: responsibility for applicant Family/Friend—Guardian Family/Friend—Power of Attorney Organizational Guardian Does this person assume decision-making authority for this applicant?

Unknown

Yesl

No

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			
lı	ncome		
Does the applicant have income? Yes	No		
Monthly Income:			
SSI:	Veteran's Benefits:		
SSDI:	Other (specify):		
Total Estimated Monthly Income:			
Н	ousing		
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 (Inc.)	dividuals with Intellectual Disabilities only)		
Alternative Family Living/ "AFL" (Indivi	duals with Intellectual Disabilities only)		
Have you applied for a housing choice voucher	orogram (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						

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					
		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 Yes No Medic least 60 days			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	
Го ensure a coordinated and	organized transition to a new place of residence,
	(MFP Applicant or Authorized Representative) hereby the Person Staff and Transition Coordinators to disclose my/the MFP and health information related to the transition process to the following

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

Description of Contact	Reason for Contacting	Notes
The Division of Fundament and	To help coordinate the transition process (if applicable).	
The Division of Employment and Independence for People with Disabilities (EIPD)	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
Individuals and/or Representatives listed on this application	To support transition planning efforts.	

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.

Ву	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		
	<u> </u>	T 0: 1			
Address	City	State	Zip	Phone	
		<u> </u>	<u>.</u>		
Type of Guardianship: P	ersonEstatePerson	and Esta	ate		
Parent (if applicant is under	the age of 18)				
Name (Last)	First		Middle Initial		
		T	<u> </u>	T	
Address	City	State	Zip	Phone	
	<u> </u>				
Type of Guardianship: Person Estate Person and Estate					
To Co	omplete the Application Please Sign	n and Da	ate Below		
Signature or Mark of Applicant			ate (mm/dd/yyyy	<i>'</i>)	
Signature of Legal Guardian/Parent (if applicable)/Authorized			Date (mm/dd/yyyy)		
Representative					

Once this form is completed, please fax to 919-882-1664 or email (password protected) to mfpinfo@dhhs.nc.gov