



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?						<input type="checkbox"/> Yes		<input type="checkbox"/> No			
Street Address:											
City:			County:			State:	NC	Zip:			
Medicaid County:			County moving to:								
Phone #:				Alternate Phone #:							
Will applicant have a Medicaid deductible upon transitioning?						<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> 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:		<input type="checkbox"/> ICF/MR		<input type="checkbox"/> ICF		<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
In institution/facility at least 3 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Meets qualified residence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicaid eligible	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Transition Coordination Agency:		
Authorized by:		
Title:	MFP Project Director	Date: