

ON LME/LEAD AGENCY LETTERHEAD

**MONEY FOLLOWS THE PERSON
REQUEST FOR TRANSITION YEAR STABILITY RESOURCES**

DATE: _____
 LME/LEAD Agency's Name: _____
 LME/LEAD Agency's CAP Provider Number: _____
 Phone: _____ Fax: _____
 Participant's Name: _____
 Participant's Medicaid Number: _____
 ___ Anticipated or ___ Actual Transition Date: _____

Please check one:
 ___ This is the first request for this participant.
 ___ This participant has accessed \$_____ prior to this request.

This request is (please check only one):

- ___ A request for transition funds BEFORE the participant's transition to be billed after transition
- ___ A request to ADVANCE transition funds from MFP BEFORE the participant's transition (will be paid back to MFP through recoupment process)
- ___ A request to bill for transition funds AFTER the participant's transition
- ___ A request to advance allowable CAP services (i.e. Home Modifications) BEFORE the transition

- o Important Note: Regular requirements/restrictions on CAP services apply

By submitting this request, LME/Lead Agency confirms that the MFP participant/representative authorizes all requests.

ITEMS REQUESTED:

- Please list items and estimated/actual expenses below. Use additional space if needed.
- Please attach written estimates or receipts (if already purchased).
- Please include brief written explanation of why these items will help the participant return to/remain in his or her community.
- Please fax to: 919-715-4159

Item	Estimated/Actual Costs (attach documentation)	Brief Explanation of Need
TOTAL		

MFP Participant/Representative

Date

LME/Lead Agency Representative Signature

Date

MFP Director/Approved By

Date