



## MONEY FOLLOWS THE PERSON ENROLLMENT REQUEST

To:  <b>FOR DDD:</b>  <b>Terre Lewis</b> <b>MFP Project Director</b> <b>(609)-689-0564</b> <b>(609) 631-2217 (Fax)</b> <a href="mailto:Terre.Lewis@dhs.state.nj.us">Terre.Lewis@dhs.state.nj.us</a>		Date	
		1. Name of Person Completing Form	Name of Care Manager
		Name of Agency	Managed Care Organization
		Telephone Number	Telephone Number
<i>The individual identified below has been approved to participate in the Medicaid Waiver Program and Money Follows the Person.</i>			
2. Name of Participant		Social Security Number	
Gender	Date of Birth	DDD MIS Number	
3a. Medicaid Number	3b. Medicare Number	4. Waiver Effective Date	
5. MFP Effective Date		6. Date HSRS Completed (DDD Only)	
7. <input type="checkbox"/> CCW <input type="checkbox"/> MLTSS			
8. Facility Address		9. Community Residence Address	
		County	
		Telephone Number	Alternate Telephone No.
10. Date of Admission to Institution (must be at least 3 months prior to date of discharge for MFP enrollment)		11. Institution Type <input type="checkbox"/> ICF/MR <input type="checkbox"/> NF <input type="checkbox"/> SCNF	
12. Residence Type <input type="checkbox"/> OH <input type="checkbox"/> OH with Family <input type="checkbox"/> Apt. with Individual Lease <input type="checkbox"/> GH with Less than 4			
13. Participant lives with Family Members <input type="checkbox"/> Yes <input type="checkbox"/> No		14. Date of Medicaid Eligibility (at least 1 day prior to waiver eligibility)	
15. Date IDT Recommends/ID's SR for MFP		16. Housing Determination Date	
17. Projected Move Date	18. Target Move Date	19. Actual Move Date	20. Quality of Life Survey Date

Please contact the project director if there are any questions about the information on this form.

**FOR OCCO: Fax this form within 24 hours to: Associate MFP Director, Fax # 609-588-3330.**

## Instructions for Completing the MFP 75 Form

1. Person Completing Form – Self Explanatory  
Enter Care Management Site, Care Manager Name and Telephone Number.
2. Enter the name of the MFP participant, the gender, Social Security Number, date of birth and (if applicable) the DDD MIS number.
3. Enter the Medicaid # and Medicare # of the individual. For DDD consumers this will begin with 90.
4. Waiver Effective Date: Should be at least one day prior to discharge.
5. MFP Effective Date: Is the same date as Discharge Date.
6. Enter date HSRS completed for DDD only.
7. Check box for the waiver program the participant will be entering. Check only ONE box. DDD will be CCW.
8. Facility Address: Address of the Nursing Facility or developmental center the participant is transitioning from.
9. Community Residence Address: The address the participant is moving to. Please provide the phone number as well as an alternate phone number.
10. Date of admission to institution: This date must be at least 3 months prior to discharge to the community.
11. Institution Type: ICF-MR = DDD Developmental Centers. NF and SCNF are Nursing Facilities or Skilled Nursing Facilities.
12. Residence Type: Type of residence the participant is moving to. Check only ONE. OH = own home APT = apartment GH = group home.
13. Participant lives with family members upon discharge – self-explanatory.
14. Date of Medicaid Eligibility – must be at least 1 day prior to discharge from the institution.
15. The date the IDT recommended or identified (ID's) the Service Recipient for MFP.
16. Housing Determination Date: Can be date of assessment for housing type or the specific date the participant identifies the housing they are moving into.
17. Projected Move Date – This is the initial projected move date. This date does not change.
18. Target Move Date – Should participant not move this date will change.
19. Actual Move Date – Self explanatory.
20. Quality of Life Survey Date: Date MFP Quality of Life Survey was completed for the participant.