



NC 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)	First	Middle Initial
Social Security Number	Applicant's Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Medicaid Number	Medicare Number	Do you need a translator? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please check your preferred method of communication: <input type="checkbox"/> In Person <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email		
Has the applicant previously participated in MFP? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Note: Participation in MFP is limited to 3 instances of application approval.		
Date of admission to this facility: Is a discharge date set? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the discharge date: If a discharge date is set, is that date flexible? <input type="checkbox"/> Yes <input type="checkbox"/> No IMPORTANT: The applicant MUST stay in the facility until they can transition under MFP! This process takes at least 30 days to set up all needed services and supports.	Type of facility: <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disabilities <input type="checkbox"/> Acute Care Hospital <input type="checkbox"/> Psychiatric Residential Treatment Facility <input type="checkbox"/> Other (list here)	
Name of Facility:	Street Address	
City	State	Zip County
Facility Social Worker / Point of Contact Name:	Email:	
	Phone	Fax
Was the applicant admitted from the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, hospital admit date:	Hospital discharge date:

Other Long-Term Care Facility Stays

Has the applicant had other stays in a Long-Term Care facility in the past year?

Yes No

(This includes skilled nursing centers, rehab centers, hospitals, intermediate care facilities, psychiatric residential treatment facilities, and state psychiatric hospitals)

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:	

Diagnoses

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:

Key Points of Contact

Legal guardian (if applicable)

Name (last)	First	Middle Initial
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Address	City	State	Zip	Phone
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Type of Guardianship Person Estate Person and Estate

Parent (if applicant is under age 18)

Name (last)	First	Middle Initial
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Address	City	State	Zip	Phone
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Type of Guardianship Person Estate Person and Estate

Family Member(s) or Other Point(s) of Contact

Name	Relationship	Phone Number / Other Means of Contact	Type of Authority:
			<input type="checkbox"/> Family / Friend – No legal responsibility for applicant <input type="checkbox"/> Family / Friend – Guardian <input type="checkbox"/> Family / Friend – Power of Attorney <input type="checkbox"/> Organizational Guardian

Does this person assume decision-making authority for this applicant?

Yes No Unknown

Name	Relationship	Phone Number / Other Means of Contact	Type of Authority:
			<input type="checkbox"/> Family / Friend – No legal responsibility for applicant <input type="checkbox"/> Family / Friend – Guardian <input type="checkbox"/> Family / Friend – Power of Attorney <input type="checkbox"/> 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):

- | | |
|--|--|
| <input type="checkbox"/> Self (no help) | <input type="checkbox"/> Family, Friend, or Corporate Guardian |
| <input type="checkbox"/> Local Contact Agency (LCA) | <input type="checkbox"/> Center for Independent Living (CIL) |
| <input type="checkbox"/> Facility listed above | <input type="checkbox"/> Private Medicaid Provider |
| <input type="checkbox"/> Managed Care Organization (MCO) | <input type="checkbox"/> Division of Employment and Independence for People with Disabilities (EIPD) |
| <input type="checkbox"/> CAP/DA Lead Agency | <input type="checkbox"/> Civic / Advocacy Group |
| <input type="checkbox"/> Area Agency on Aging (AAA) | <input type="checkbox"/> Program of All-Inclusive Care for the Elderly (PACE) |
| <input type="checkbox"/> Other (please list): | |

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

Income

Does the applicant have income? Yes No

Monthly Income

SSI:

Veteran's Benefits:

SSDI:

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? (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)

Do you need help finding housing? Yes No

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

Community Support System

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 to appointments, groceries, or events, meal 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 (e.g., transportation, meals, emergencies, 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 need regular hands-on assistance, or 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, or I need support sometimes but not all of the time)	I Don't Need Any Support—I can do it myself.	Notes (Please note any specific information you want to share. Also, if you know someone specific who can help you, please indicate their name)
Moving around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting out of bed or a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing, dressing, taking care of my bathroom needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Home maintenance, laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daily decision-making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 pages to 919-882-1664, or email (password protected) to mfpinfo@dhhs.nc.gov



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 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 and 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 Contact	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
Individuals and / or Representatives listed on this application	To support transition planning efforts.	
<p style="text-align: center;">IMPORTANT</p> <p style="text-align: center;">If you have concerns about MFP staff and transition coordinators contacting any of the entities listed above, please explain here:</p>		

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 nontreatment 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

Transitions take time. It will take a **minimum of 30 days**, and most likely longer, for MFP to put all services and supports in place to facilitate a transition.

- I understand that the applicant must remain in the facility until transition can take place with MFP.
- I understand that if the applicant leaves the facility before MFP can facilitate the transition all MFP services and supports will be stopped and I will be disenrolled from the program.
- I understand the applicant is only allowed to apply for MFP three (3) times, and by leaving the facility before transitioning with MFP one of the applications is being used.

To complete the application please sign and date below

Signature or Mark of the Applicant	Date (MM/DD/YYYY)
Signature of Legal Guardian/Parent / Authorized Representative (if applicable)	Date (MM/DD/YYYY)

Complete this form, as well as the MFP Application, and fax all pages to 919-882-1664, or email (password protected) to mfpinfo@dhhs.nc.gov

MFP Staff Use Only		
Date Application Received	Date Application Checked	Date Linkage email: Sent
Income		
Income from NCFAST: \$ <input type="checkbox"/> No Income in NC FAST Listed. Please confirm with participant and coordinate any necessary activity with Local Social Security Office <input type="checkbox"/> Deductible Not Likely <input type="checkbox"/> Deductible Possible. Please work with the participant to confirm with local Adult Medicaid staff at DSS in Medicaid County: of Origin. As of April 1, 2025, the income limit has increased to \$1,305.00.		
Criminal History		
Applicant has a criminal record identified <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicaid and Medicare Information		
Medicaid County:	Facility County:	Facility Type
Medicaid Type: <input type="checkbox"/> MAD <input type="checkbox"/> MAA <input type="checkbox"/> Other: (**Please be aware that NOT all Medicaid types are accepted by every waiver program. The Medicaid type may need to be changed before waiver is approved **)		
Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No		
Approval Details		
Meets qualified institution/facility <input type="checkbox"/> Yes <input type="checkbox"/> No	Meets qualified residence <input type="checkbox"/> Yes <input type="checkbox"/> No	
In institution / facility at least 60 days <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	
Application Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	MFP ID	
Transition Entity	Transition Coordinator	
Linkage Email: Sent to: <input type="checkbox"/> Transition Coordinator Listed Above <input type="checkbox"/> Statewide Transition Coordination Entity <input type="checkbox"/> Institution Social Worker/Discharge Coordinator: <input type="checkbox"/> MCO Agency:	<input type="checkbox"/> Responsible Party: <input type="checkbox"/> MFP Associate Director: <input type="checkbox"/> PACE Entity <input type="checkbox"/> Other (Specify):	
Authorized By		
Print Name:		
Signature:		Date: