MONEY FOLLOWS THE PERSON
ENROLLMENT REQUEST

To: **FOR DDD:** **Terre Lewis** **MFP Project Director** **(609)-633-7356** **(609) 292-1551 (Fax)** **Terre.Lewis@dhs.nj.gov.**	Date	
	1. Name of Person Completing Form	Name of Care Manager
	Name of Agency	Managed Care Organization
	Telephone Number	Telephone Number

The individual identified below has been approved to participate in the Medicaid Waiver Program and Money Follows the Person.

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. ☐ CCW ☐ MLTSS	
8. Facility Address	**9.** Community Residence Address
	County
	Telephone Number / Alternate Telephone No.
10. Date of Admission to Institution (must be at least 2 months prior to date of discharge for MFP enrollment)	**11.** Institution Type ☐ ICF/MR ☐ NF ☐ SCNF
12. Residence Type ☐ OH ☐ OH with Family ☐ Apt. with Individual Lease ☐ GH with Less than 4	
13. Participant lives with Family Members ☐ Yes ☐ 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 N/A

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

FOR OCCO: Email this form within 5 days: Alisa.Mead@dhs.nj.gov

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. (DDD: same date as Actual Move Date)
5. MFP Effective Date: Is the same date as Actual Move 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 2 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.