MONEY FOLLOWS THE PERSON

TRACKING FORM

The purpose of this form is to:

1. Track MFP days
2. Provide statistics to CMS on reasons for readmission

Participant's Name: _____ **Medicaid No.:** _____

1. Start Date (day of move to community): _____
   This is the date of discharge from the NF to the community setting, day one (1) of the 365 days under the MFP program

2. Date of Nursing Facility Readmission: _____ OR Date of Hospital Admit Over 30 Days: _____
   If applicable, if after a hospitalization participant requires a NF stay or is participant enters a NF for any reason (see below)

3. Reason for Readmission:

   - ☐ Needs exceed available/allowable services
   - ☐ Change in caregiver status, unable to provide care as before
   - ☐ Illness/deterioration in ADL function requiring NF stay
   - ☐ Decrease in cognitive function
   - ☐ Decrease in mental health
   - ☐ Loss of housing
   - ☐ Request of guardian and/or participant

4. Date of Discharge Back to Community: _____
   This date will restart the clock for a total of 365 days (days in the NF are not counted as part of the 365)

5. Number of Days Spent in NF: _____
   See above, number of days need to be monitored

6. Date of MFP Termination: _____

   Reason:

   - ☐ No longer meets NF Level of Care/withdrawn
   - ☐ Transferred into Assisted Living Residence
   - ☐ Illness/deterioration in functioning requiring placement in NF
   - ☐ Expired (reason): _____
   - ☐ Other: _____

Please submit this form to the Associate MFP Director via email at alisa.mead@dhs.state.nj.us, or via fax to 609-588-3330.

Care Manager's signature: _____ MCO: _____

CM Phone #: _____ CM Fax #: _____

CM Email: _____