

Montana's Community Choice Partnership Money Follows the Person (MFP) Demonstration Project Request for Referral

Montana's Money Follows the Person (MFP) program is intended to help people transition from institutional settings back to their community. Institutional settings include nursing facilities, hospitals, Montana Developmental Center (MDC), Psychiatric Residential Treatment Facilities (PRTFs), Montana State Hospital (MSH), and Montana Mental Health Nursing Care Center. MFP provides additional services and supports to help individuals with complex needs live safely in a home or community based setting.

To be eligible for Montana's Money Follows the Person (MFP) funding and services, a person must:

- Reside in an institutional care setting for 90 days at the time of transition.
- Be eligible for Medicaid at least one day prior to transfer to a community setting.
- Be eligible for certain Waiver or State Plan Programs.

To make a referral: Complete this form online at <http://www.dphhs.mt.gov/mfp/> or print it and fax it to 406.444.7743 or call 406.444.0933. Email questions to MoneyFollowsThePerson@mt.gov (do not attach this form to an email because it is not secure).

**** Referral does not guarantee placement into MFP. ****

Has the consumer expressed an interest in living in the community? Yes No

Applicant/Consumer Information			
Name:		DOB:	Age:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Medicaid Eligible: <input type="checkbox"/> Y <input type="checkbox"/> N	Medicaid #:	Phone #:
Address:		City:	State: Zip:
Medicare Eligible: <input type="checkbox"/> Y <input type="checkbox"/> N	Medicare #:	Veteran: <input type="checkbox"/> Y <input type="checkbox"/> N	

Referral Source Information			
Name:		Date of Referral:	
Agency:			
Address:		City:	State: Zip:
Phone:		Email:	
<input type="checkbox"/> Self	<input type="checkbox"/> Discharge planner	<input type="checkbox"/> AAA/ADRC	<input type="checkbox"/> Independent Living
<input type="checkbox"/> Family	<input type="checkbox"/> MH Ombudsman	<input type="checkbox"/> OPA	<input type="checkbox"/> Facility
<input type="checkbox"/> Provider/Case Mgr.	<input type="checkbox"/> LTC Ombudsman	<input type="checkbox"/> Program/Agency	<input type="checkbox"/> Other:
<input type="checkbox"/> MDS Section 'Q'	<input type="checkbox"/> APS	<input type="checkbox"/> MPQH	

Institution/In Patient Facility Information			
Facility Name:			
Date of admission:		Location:	
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Hospital	<input type="checkbox"/> MDC	<input type="checkbox"/> PRTF
<input type="checkbox"/> MH Nursing Care Center			<input type="checkbox"/> MSH

What is the person's primary diagnosis?

What are the person's needs (care, services, housing)? Provide a brief overview.

Where does person want to live?

Does the person have housing in the community? Y N

If not have they applied for subsidized housing? Y N

Does the person qualify for a waiver? Y N

If yes, which waiver: Big Sky SDMI 0208 1915(i) unknown

