***Commonwealth of Massachusetts***

***Executive Office of Health and Human Services***

[*www.mass.gov/masshealth*](http://www.mass.gov/masshealth)

# Massachusetts Money Follows the Person Demonstration Referral Form

The Money Follows the Person (MFP) Demonstration helps elders and people with disabilities move from nursing facilities, chronic disease or rehabilitation hospitals, or other qualified facilities back to the community.

Please complete the following information to submit a referral. Please note that any field with an   
asterisk (\*) is required.

## Section 1: Applicant information

Applicant Name\*

* Applicant first name\*
* Applicant last name\*

Date of birth\*:

MassHealth ID # (must be 12 digits)

Phone Number\*

Email address

Current facility type - Please select one:

* Nursing Facility
* Chronic Disease and Rehabilitation Hospital
* Psychiatric Hospital
* Department of Public Health Hospital
* Intermediate Care Facility for Individuals with Intellectual Disabilities

Facility name

Address\*

* Address Line 1\*
* Address Line 2
* City\*
* State\*
* ZIP code

Facility phone number

Facility contact name

Admission date

Gender Identity - Please select one:

* Male
* Female
* Other

Preferred spoken language

Preferred written language

Does the applicant need an interpreter?

* Yes
* No

## Section 2: Guardianship

Does the applicant have a legal guardian?\*

* Yes
* No

If Yes, please fill in the following fields in Section 2.

Legal guardian first name

Legal guardian last name

Address

* Address Line 1
* Address Line 2
* City
* State
* ZIP code

Legal guardian phone number

Legal guardian email address

## Section 3: Who is filing out this form?

Submitter Name\*

Submitter first name\*

Submitter last name\*

Relationship to applicant\*

Title

Submitter Address

* Address Line 1
* Address Line 2
* City
* State
* ZIP code

Submitter phone number\*

Submitter email address\*

Is referral due to MDS Section Q?

* Yes
* No

Is applicant aware of this referral?\*

* Yes
* No

## Section 4: Is the applicant already working with a state agency?

If known, please complete the following:

Agency *-* Please select one

* Department of Developmental Services (DDS)
* Massachusetts Rehabilitation Commission (MRC)
* Executive Office of Elder Affairs (EOEA) or Aging Services Access Point (ASAP)
* Department of Mental Health (DMH)
* Other
* Unknown

Agency Contact Name

* First name
* Last name

Agency Contact Address

* Address Line 1
* Address Line 2
* City
* State
* ZIP code

Agency Contact Phone

Agency Contact Email

To submit this Referral Form to the MFP Demo program, fill out this form, save it, and email it to the MFP Project Office at [MFP@mass.gov](mailto:MFP@mass.gov). The Subject line should be MFP Demo Referral.

Please note: If you are a state agency or organization sending on behalf of the applicant, be sure to send the email securely and in compliance with any applicable privacy laws.

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## End of Form