



# 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. Note that any field with an asterisk (\*) is required.

## Date referral submitted

### Section 1: Individual's information

|   |                                     |           |
|---|-------------------------------------|-----------|
| Individual's first name*  | Individual's last name*             |           |
| Date of birth*  | MassHealth ID # (must be 12 digits) |           |
| Phone number*   | Email address                       |           |
| Current facility type   | Facility name                       |           |
| Address*  |                                     |           |
| City*   | State*                              | ZIP code* |
| Facility phone number   | Facility contact name               |           |
| Admission date  | Projected discharge date (if known) |           |
| Does the individual need housing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Gender Identity                     |           |
| Preferred spoken language   | Preferred written language          |           |
| Does the applicant need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No                            |                                     |           |

**Section 2: Guardianship and/or Invoked Health Care Proxy**

Does the individual 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

\_\_\_\_\_  
Legal guardian phone number

\_\_\_\_\_  
Legal email address

Does the individual have an invoked health care proxy?\*  Yes  No

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

\_\_\_\_\_  
Invoked health care proxy first name

\_\_\_\_\_  
Invoked health care proxy last name

\_\_\_\_\_  
Invoked health care proxy phone number

\_\_\_\_\_  
Invoked health care proxy email address

**Section 3: Who is filling out this form?**

\_\_\_\_\_  
Submitter first name\*

\_\_\_\_\_  
Submitter\* last name

\_\_\_\_\_  
Relationship to individual\*

\_\_\_\_\_  
Title

Submitter Address\* \_\_\_\_\_

\_\_\_\_\_  
City\*

\_\_\_\_\_  
State\*

\_\_\_\_\_  
ZIP code\*

\_\_\_\_\_  
Submitter phone number\*

\_\_\_\_\_  
Submitter email address\*

Is the referral due to MDS Section Q?  Yes  No

Is the individual aware of this referral?\*  Yes  No

**Section 4: Is the individual already working with a state agency?**

If known, please complete the following:

Agency

Agency Contact Name

\_\_\_\_\_

First name

\_\_\_\_\_

Last name

\_\_\_\_\_

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 individual, be sure to send the email securely and in compliance with any applicable privacy laws.

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**End of Form**