

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES  
DIVISION OF LONG-TERM CARE**

**REQUEST FOR ENROLLMENT IN MONEY FOLLOWS THE PERSON PROGRAM**

Individual's Name:	
Medicaid ID Number:	
Support Coordinator/Case Manager/ Transition Coordinator	
Provider ID Number:	

Medicaid Waiver Type: (check the appropriate waiver box)

- AIDS     
  EDCD     
  IFDDS     
  ID     
  TECH

Criteria: (Check each item as it is discussed with individual.)

- Individual has given consent to participate in Money Follows the Person Program.
- Individual is a resident of the Commonwealth of Virginia;
- Individual has been living for at least 90 consecutive days in a hospital, nursing facility (any days spent in short-term skilled rehabilitation services do not count towards the 90 days), intermediate care facility for individuals with developmental disabilities (ICF-DD), long-stay hospital, institute for mental disorders (IMD), psychiatric residential treatment facility (PRTF), or a combination thereof;
- Individual has received Medicaid benefits for inpatient services for at least one day prior to MFP enrollment.
- Individual is transitioning to a “qualified” residence; (check only one box)**
  - A home that they or their family member owns or leases;
  - An apartment with an individual lease, with lockable entry and exit, which includes living, sleeping, bathing and cooking areas over which they or their family has domain and control; or
  - A residence, in a community-based residential setting, in which no more than four unrelated individuals reside.
- Individual has received a copy of the Money Follows the Person Project Guidebook on \_\_\_\_\_ (Insert date copy was provided.)

By submitting this request for enrollment the Transition Coordinator or Support Coordinator/Case Manager acknowledges that all criteria listed above have been met.

By submitting this enrollment request, the Transition Coordinator or Support Coordinator/Case Manager:

1. Attests that the individual applying to the MFP program can reside safely in the community based upon the assessment and support plan developed during the transition process as required for enrollment into a Medicaid waiver.

2. Assures that there is documentation for all criteria listed above and the information is available in the individual's record for review.

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SIGNATURE – Support Coordinator/Case Manager or Transition Coordinator

Date Signed