Request for Additional MFP Transition Services

MFP Field Personnel note: Services listed on this form must be needed by the participant and not initially identified during pre-discharge transition service planning (ITP/ISP) by the team. The participant must have budget funds available to request additional MFP services. The MFP participant initials each additional service.

Participant First Name: **Participant Last Name**:

Participant Medicaid ID#: **Participant Date of Birth**:

Participant Address:

Participant City: **Zip**: **County**: **Waiver Name:**

Participant Phone Number: **Other Contact Name**: **Other Phone**:

Date of ITP: **Date of Discharge:** **Date of Request**:

MFP TRANSITION SERVICE CODE	**RATIONALE** (provide justification - describe need for additional service(s) for successful community living)	**BUDGET AMOUNT**	**MFP PARTICIPANT INITIAL**
	Total Budget This Request		
Bring Forward Amount of Budget Already Authorized:			

TOTAL BUDGET (cannot exceed $25,000 for all MFP services):

MFP Field Personnel Name:

Region/Office: **Phone**: **Email**:

Field Personnel note: Send this completed form to the FI and DCH/MFP Office via **File Transfer Protocol (FTP).** Submit completed reimbursement documentation (i.e. updated ITP, *Vendor Import File*, etc.) to Fiscal Intermediary via **FTP** and to DCH/MFP Office by **FTP**.