



Money Follows the Person



Referral Form

Date (mm/dd/yyyy): _____

Person making referral: _____

Agency making referral: _____ Phone Number: _____

Person Referred-Name: _____ Phone Number: _____

Date of Birth (mm/dd/yyyy): _____ Age: _____

Institution/Nursing Facility: _____

Address: _____

City: _____ ST: _____ ZIP: _____ County: _____

Contact Person: _____ Phone Number: _____

Admission Date to Nursing Facility (mm/dd/yyyy): _____

Anticipated Referral CCSP SOURCE ICWP Date Referred: _____

NOW COMP C-BAY Date Referred _____

Currently on wait list for: CCSP SOURCE ICWP

NOW COMP C-BAY

Letter or contact info from the waiver: Yes No

Case Manager if assigned _____ Phone Number: _____

Interested Parties:

Name: _____ Relationship: _____

Street: _____ Phone Number: _____

City _____ ST _____ ZIP: _____

Name: _____ Relationship: _____

Street: _____ Phone Number: _____

City _____ ST _____ ZIP: _____

Pertinent Information: _____

Money Follows the Person (MFP)

Department of Community Health

Medicaid Division, Aging & Special Populations

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