



# 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: \_\_\_\_\_

**Inpatient Facility:**

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Admission Date to Inpatient Facility (mm/dd/yyyy): \_\_\_\_\_

**Anticipated Referral:** CCSP  SOURCE  ICWP  Date Referred: \_\_\_\_\_  
NOW  COMP  Other \_\_\_\_\_  Date Referred \_\_\_\_\_

Currently on wait list for: CCSP  SOURCE  ICWP   
NOW  COMP  Other \_\_\_\_\_

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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