



# Money Follows the Person



## Referral Form

Date: \_\_\_\_\_

**Referred By:** \_\_\_\_\_

Agency: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Name of Person Referred:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Institution/Nursing Home:** \_\_\_\_\_

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

City/Zip: \_\_\_\_\_ County: \_\_\_\_\_

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

Admission Date to Nursing Home: \_\_\_\_\_

**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/Zip \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City/Zip \_\_\_\_\_

**Pertinent Information:** \_\_\_\_\_

Money Follows the Person (MFP)

Department of Community Health

Medicaid Division, Aging & Special Populations

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