MFP Participant Enrollment Status Change Form

MFP Field Personnel: complete the text boxes and check boxes provided to identify changes in the enrollment status of an MFP participant.

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

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

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

Date of Discharge (mm/dd/yyyy): **Waiver**: - **OR -** ☐ **MFP CBAY**

Status Change Type: MFP Participation

☐ **Ended – Date: _____**
☐ **Participant was Re-institutionalized – Date:_____**
☐ **Began - (Re-enrollment) - Date: _____**
- **New Project End Date**: _____
☐ **Participant Moved** (fill in new address) – **Date**: _____

New Address: **New City:** **New Zip:** **New County**:

If enrollment ended, check reason:

☐ Completed 365 days of participation (01)
☐ Reinstitutionalized (02)
☐ Died (03) – **Date** _____
☐ Moved (04)
☐ No longer needed/wanted services (05)
☐ Chose non-qualified residence type (06)
☐ Did not participate in the planning process (07)
☐ Other (08) Specify: _____

If re-institutionalized, check reason:

☐ Acute care hospital stay, long term rehabilitation (01)
☐ Deterioration in cognitive functioning (02)
☐ Deterioration in health (03)
☐ Deterioration in mental health (04)
☐ Loss of qualified residence (05)
☐ Loss of personal care giver (06)
☐ By request of participant or guardian (07)
☐ Lack of sufficient community services (08)

If MFP participant re-enrolled or moved, check type of qualified residence used after move:

☐ Home owned by participant (01)
☐ Home owned by family member (02)
☐ Apt. leased by participant, not assisted living (03)
☐ Apt. leased by participant, assisted living (04)
☐ Group home of no more than 4 people/PCH (05)

☐ Participant lives with family members (check for yes)

Notes:

MFP Field Personnel Name:

Region/Office: Phone: Email:

Note: Send completed form to the appropriate coordinating agency via File Transfer Protocol**.**