



Money Follows the Person Referral Form

Date of referral (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 Name: _____

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 CBAY Date Referred _____

Currently on wait list for: CCSP SOURCE ICWP

NOW COMP CBAY

Letter or contact info from the waiver: Yes No

Case Mgr/Care Coordinator if assigned _____ Phone Number: _____

Interested Parties:

Name: _____ Relationship: _____

Street: _____ Phone Number: _____

City: _____ ST _____ ZIP: _____

Name: _____ Relationship: _____

Street: _____ Phone Number: _____

City: _____ ST _____ ZIP: _____

Pertinent Information: _____

Return completed referral form by Email to: gamfp@dch.ga.gov; Or mail completed form to:

Money Follows the Person (MFP)
Georgia Department of Community Health
Medicaid Division, Aging & Special Populations
2 Peachtree St. NW, 37th Floor
Atlanta, GA 30303
Website: dch.georgia.gov/mfp

For questions or assistance making a referral, contact the Project Director at: 404-651-9961