



MFP Authorization for Pre and Post-Transition Services



MFP Facilitator (OC, TC, PLA, CE): complete the following to authorize MFP services.

Participant First Name: _____ **Participant Last Name:** _____
Participant Medicaid #: _____ **Participant Date of Birth:** _____
Participant Address: _____ **Participant City:** _____ **State:** _____ **Zip:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
(Anticipated) Transition Date: _____ **COS Waiver Type:** _____
CHECK ONLY ONE: this is a(n) **Initial Authorization** **Revised Authorization**

Vendor	Pre Transition Services	\$'s Authorized

Total Pre-Transition \$'s Authorized:

(Pre-transition services are not to exceed \$10,244.00 in the 365 day demonstration period).

Vendor	Post Transition Service	\$'s Authorized

Total Post-Transition \$'s Authorized:

Post-Transition services are not to exceed \$26,418 in the 365 day demonstration period.

MFP Facilitator (OC, TC, PLA, CE) Name: _____

Office Location: _____ Phone: _____ Email: _____

Authorizing Signature: _____ Date Signed: _____

Notice: (Step 1) Send this completed *Authorization* to Fiscal Intermediary via **File Transfer Protocol (FTP)**. (Step 2) Send this complete *Authorization* to the DCH/MFP Office via **File Transfer Protocol**.