Money Follows the Person (MFP) Transition Screening Form

Participant Name: _____

(Screener note: Establish rapport before beginning the screening process).

1. Do you want to live somewhere other than this facility? ☐ Yes ☐ No

Screening Type/Date: (Check only one box) ❑ Initial F2F Screening _____ (mm/dd/yyyy) ❑ F2F Re-screening _____ (mm/dd/yyyy) Screener's Name: _____ Screener's Contact: _____		Date of Initial MFP referral: _____ (mm/dd/yyyy) Date of Referral To Waiver: _____ (mm/dd/yyyy)	Referral Source: ❑ Nursing Facility ❑ MDSQ ❑ Self ❑ Family Member ❑ AAA, CIL, LTCO, etc. ❑ ADRC ❑ Waiver Case Mgr ❑ Personal Care Home ❑ Assisted Living Facility ❑ Legal Representative ❑ Other: (specify) _____	Notes:
Gender: ❑ **M**ale ❑ **F**emale	Ethnicity: ❑ African American ❑ Asian or Pacific Is. ❑ Hispanic ❑ Latino ❑ Native American ❑ White ❑ Other: _____	Population (Check only one): ❑ Older Adult (60+) ❑ Physical Disability ❑ TBI ❑ DD ❑ Other (specify): _____	Referral to: ❑ CCSP ❑ SOURCE ❑ Independent Care Waiver (ICWP) ❑ NOW/COMP ❑ State Plan Service ❑ Non-Medicaid HCBS ❑ Other (specify): _____	Refused/ineligible: ❑ in NF < 90 days ❑ no Medicaid ❑ didn't meet LoC ❑ costs > than NF ❑ insufficient community svs ❑ didn't locate qualified residence ❑ didn't want to participate ❑ changed mind ❑ family/guardian refused permission ❑ Other _____
Primary Language: ❑ American Sign Language ❑ English ❑ Spanish ❑ French ❑ Korean ❑ Other (specify): _____			❑Deaf or Hard of Hearing Requires Interpreter: ❑ Yes ❑ No Interpreter:_____ Contract: _____	

(Screener Note: List persons participating in the screening or attach sign-in sheet).

Personal Data:

2. Medicaid # _____ Medicare # _____

3. First Name:_____ MI:__ Last Name:_____

4. SSN: _____--_____--_____ Date of Birth (mm/dd/yyyy) _____

5. Facility Name and Address: _____

   City: _____, Zip: _____ Phone: _____

6. Discharge Planner/Contact: _____ Phone : _____

Participant Name: _____

7. Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Widowed ☐ Sep ☐ Other: _____

8. Spouse Name and address: _____

_____

9. Are you a veteran? ☐ Yes ☐ No. Did you serve during wartime? ☐ Yes ☐ No

10. Do you have a guardian: ☐ Yes ☐ No If yes, list name and contact information:

_____

(Screener note: Ask the person who they would like to include in the screening process—family members, friends, etc. If person has a guardian, stop the interview and reschedule the screening when these persons can participate).

Background Data:

11. Where did you live before you came here? _____

12. What were the reasons you entered this facility?_____

_____

13. How long have you lived here at this facility? _____ years _____ months
(Screener note: to qualify for MFP, the person must have resided in the nursing facility/institution for a minimum of 90 consecutive days).

14. Do you have any family living in this area? ☐ Yes ☐ No
If yes, list name, phone number and address:

_____

_____

15. Do you have a close relationship with family member(s) or friend(s) that can assist you: ☐ Yes ☐ No

(Screener note: At this point in the interview, introduce, review and obtain signature on *Authorization for Release of Information* and *Informed Consent for MFP*).

16. May we contact a family member(s) or friends(s) to meet with you and us to discuss your move into the community? ☐ Yes ☐ No

17. If yes, please provide their name(s) and telephone number(s): _____

_____

18. Do you have a home to move back into? ☐ Yes ☐ No

If yes, the address of your home: _____

Participant Name: _____

19. If applicable, does anyone live in your home? ☐ Yes ☐ No

What are their names and relationship to you? _____

_____

(Screener note: introduce MFP qualified housing options. Tell the candidate that while MFP will assist the person to locate qualified housing, the MFP program does not cover the cost of rent or utilities and that to participate in MFP, the person must enter one of the following types of qualified housing--

- A home owned or leased by the individual or the individual's family member,
- An apartment with an individual lease, with lockable entry door, that includes living, sleeping and bathing and cooking areas over which the individual or the individual's family have domain and control, or
- A residence, in a community based residential setting, in which no more than 4 unrelated individuals reside)

20. Which type of qualified housing are you interested in and why? _____

_____

21. Do you have someone you want to live with? ☐ Yes ☐ No
If yes, list contact information _____

_____

22. Did you receive services in your home before coming to (name of facility)?

☐ Yes ☐ No If yes, what service(s): _____

_____

23. Are you currently on a waiver waiting list for home & community based services?
☐ Yes ☐ No If so, which waiver? _____

24. Do you have a letter or contact information from the waiver? ☐ Yes ☐ No

If yes, where is the letter or contact information and/or who can bring these to

you? _____

_____

_____

(Screener note: contact the waiver program manger for this information).

Participant Name: _____

Financial Data:

(Screener note: Review facility records to obtain or confirm this information. The signed informed consent should allow you to obtain these records).

25. Income and Resources:

SOURCE	MONTHLY AMOUNT	PAYEE
☐ SSDI ☐ SSI ☐ SS Retirement		
PENSION BENEFITS		
TRUST PROCEEDS		
INHERITANCE		
VETERAN'S COMPENSATION		
CASH		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
SAVINGS ACCOUNT(DESIGNATED BURIAL)		
CEMETERY PLOT		
RAILROAD RETIREMENT		
LIFE INSURANCE		
CERTIFICATE OF DEPOSIT		
OTHER (SPECIFY)		
OTHER (SPECIFY)		
OTHER (SPECIFY)		
OTHER (SPECIFY)		

Participant Name: _____

26. Who is paying for your stay here at (this facility)? _____

_____

27. Are you Medicaid eligible, but subject to transfer of asset penalty?
☐ Yes ☐ No ☐ Don't Know (Screener note: check facility records)

Health Care Needs:

28. Disability/Diagnoses (include Self-Reported Diagnoses): _____

_____

29. Who is your doctor here at (name of facility)?

_____

30. Do you have a primary care doctor in the community? ☐ Yes ☐ No

If yes, what is her/his name and contact information? _____

_____

31. Do you need help taking your daily medications? ☐ Yes ☐ No

Describe assistance needed: _____

_____

32. What specialized medical equipment (DME) and assistive technology devices do you use?

_____

_____

_____

_____

_____

33. Which equipment or devices need to be obtained because you don't own them or they need to be replaced?

_____

_____

_____

Money Follows the Person (MFP) Transition Screening Form

Participant Name: _____

34. Functional Needs -

See KEY below for instructions to complete:

Function: Ask, "Do you need help with (activities below)? _____ (observe person doing activity when possible)	**Impairment:** If assistance needed, check yes	**Unmet Need:** Ask: Do you have an **unmet need for** help with (activities) _____ in the community?	**Comments: Identify sources of assistance in the community, resources, assistive technology, DME used. Describe special needs and circumstances that should be taken into account when developing a plan for services and supports**
1. Eating	☐ Yes ☐ No	☐ Yes ☐ No	
2. Bathing	☐ Yes ☐ No	☐ Yes ☐ No	
3. Grooming	☐ Yes ☐ No	☐ Yes ☐ No	
4. Dressing	☐ Yes ☐ No	☐ Yes ☐ No	
5. Transferring	☐ Yes ☐ No	☐ Yes ☐ No	
6. Continence	☐ Yes ☐ No	☐ Yes ☐ No	
7. Managing Money	☐ Yes ☐ No	☐ Yes ☐ No	
8. Telephoning	☐ Yes ☐ No	☐ Yes ☐ No	
9. Preparing Meals	☐ Yes ☐ No	☐ Yes ☐ No	
10. Laundry	☐ Yes ☐ No	☐ Yes ☐ No	
11. Housework	☐ Yes ☐ No	☐ Yes ☐ No	
12. Outside Home	☐ Yes ☐ No	☐ Yes ☐ No	
13. Routine Health	☐ Yes ☐ No	☐ Yes ☐ No	
14. Special Health	☐ Yes ☐ No	☐ Yes ☐ No	
15. Being Alone	☐ Yes ☐ No	☐ Yes ☐ No	

KEY

Assistance Needed in the Community

Ask: **Do you need help with _____ (activities listed above #1-15)?**

When appropriate, observe the person in the activity.

Unmet Need for Care – when person returns to the community

Ask: **When you return to the community, do you have an unmet need for someone to help you with _____ (activities listed above #1-15)?**

If participant has assistance of family/friend/caregiver or assistive device, the answer would be **NO.** If participant **has no assistance**, the answer would be **YES (there is an unmet need for care).** Note observations in case comments.

Participant Name: _____

35. Home Community Based Service (HCBS) referral to:
☐ CCSP (AAA/Gateway)
☐ SOURCE (SOURCE Case Management)
☐ Independent Care Waiver (ICWP) (GMCF)
☐ NOW/COMP Waiver (Regional DBHDD or DBHDD-DDD/MFP Office)
☐ State Plan Services (list) _____
☐ Non Medicaid HCBS (specify) _____

36. Date of referral to waiver _____ (mm/dd/yyyy).

37. Date HCBS application submitted: _____ (mm/dd/yyyy)

38. Date HCBS waiver assessment completed: _____ (mm/dd/yyyy)

39. I DO NOT wish to participate in MFP:

Signed: _____ Date: _____

Document Checklist:

(Screener note: attach the following documents. Send these copies and copy of completed Screening Form with referral to AAA/Gateway and/or GMCF).

☐ Copy of *MFP Informed Consent for Participation*
☐ Copy of *Authorization for Use or Disclosure of Health Information*
☐ Copy of Medication Administration Record (MAR) or list of current medications
☐ Copy of State Medicaid Card
☐ Copy of Medicare Card
☐ Copy of Social Security Card
☐ Copy of Legal documents that cover guardianship (on file at institution)
☐ Copy of Documents that cover Power of Attorney (on file at institution)
☐ Nursing Home face-sheet
☐ Other (Specify) _____

Notes: _____

_____

OC/TC Name:_____ Date: _____

OC/TC Phone: _____ Email: _____

Note to OC/TC: the *MFP Screening Form* must be submitted even when the person being screened refuses participation or is found to be ineligible. If the person refuses participation, be sure Question 39 is signed.

Send this completed *MFP Screening Form* to the DCH/MFP Office by File Transfer Protocol (FTP).