



Request for Additional MFP Transition Services

MFP Field Personnel note: Complete this form - 1) if the initial budget for the transition service(s) was inadequate AND the service funding cap has not been reached, and/or 2) the transition service was not initially identified during transition service planning (i.e., after discharge to the community, the need for the additional transition service(s) listed below became apparent). The MFP participant initials each additional service and/or additional amounts authorized.

Participant First Name: _____ **Participant Last Name:** _____
Participant Medicaid ID#: _____ **Participant Date of Birth:** _____
Participant Address: _____
Participant City: _____ **Zip:** _____ **County:** _____ **Waiver Name:** _____
Participant Phone Number: _____ **Other Contact Name:** _____ **Other Phone:** _____
Date of ITP/ISP: _____ **Date of Discharge:** _____ **Date of Request:** _____

MFP TRANSITION SERVICE CODE	*Justification for Additional MFP Services (describe need for additional MFP service(s) or additional amount authorized, for successful community living)	**INITIAL AMOUNT AUTHORIZED	***ADDITIONAL AMOUNT AUTHORIZED	MFP PARTICIPANT INITIAL

***When additional transition services are identified after discharge to the community, the planning document (ITP/ISP) must be updated to reflect these changes.**

****Initial Amount Authorized plus ***Additional Amount Authorized together cannot exceed individual MFP service caps; see Appendix B: MFP Services and Rate Table.**

MFP Field Personnel Name: _____

Region/Office: _____ **Phone:** _____ **Email:** _____

Field Personnel note: Send this completed form to the FI and DCH/MFP Office via **File Transfer Protocol (FTP)**. Submit completed reimbursement documentation (i.e. updated ITP, *Vendor Import File*, etc.) to Fiscal Intermediary via **FTP** and to DCH/MFP Office by **FTP**.