



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

Check Type(s) of Status Change and add Dates	Check Reason – Select Only One Reason per Type
<input type="checkbox"/> Participation <u>Ended</u> or was <u>Suspended</u>ⁱ Date participation ended: _____ Or Date participation was suspended: _____	<input type="checkbox"/> Completed MFP period of participation (01) <input type="checkbox"/> Suspended eligibility (02) <input type="checkbox"/> Reinstitutionalized (03) <input type="checkbox"/> Died (04) – Date _____ <input type="checkbox"/> Moved (provide new address below) (05) <input type="checkbox"/> No longer needed services (06) <input type="checkbox"/> Other (07) Specify: _____
<input type="checkbox"/> Participant was <u>reinstitutionalized</u> Date reinstitutionalized: _____	<input type="checkbox"/> Acute care hospital stay, followed by long term rehabilitation (01) <input type="checkbox"/> Deterioration in cognitive functioning (02) <input type="checkbox"/> Deterioration in health (03) <input type="checkbox"/> Deterioration in mental health (04) <input type="checkbox"/> Loss of housing (05) <input type="checkbox"/> Loss of personal care giver (06) <input type="checkbox"/> By request of participant or guardian (07) <input type="checkbox"/> Lack of sufficient community services (08)
<input type="checkbox"/> Participant <u>reactivated/re-enrolled</u> Date participation <u>began</u>^{ii,iii}: _____	New Project End Date: _____
<input type="checkbox"/> Participant <u>moved</u> (fill in new address) Date moved: _____	New Street Address: _____ New City: _____ New Zip: _____ New County: _____ Check type of qualified residence used after move: <input type="checkbox"/> Home owned by participant (01) <input type="checkbox"/> Home owned by family member (02) <input type="checkbox"/> Apt. leased by participant, not assisted living (03) <input type="checkbox"/> Apt. leased by participant, assisted living (04) <input type="checkbox"/> Group home/PCH with no more than 4 unrelated people (05) <input type="checkbox"/> Participant lives with family members (check for yes)

Notes:

MFP Field Personnel Name: _____

Region/Office: _____

Phone: _____

Email: _____

ⁱ When an MFP participant is readmitted into an inpatient facility for a period of 30 days or less, the participant remains enrolled in MFP. When an MFP participant is readmitted into an inpatient facility for a period of time greater than 30 days (31 days or more), the participant is considered suspended from MFP. During the suspension, MFP field personnel are required to continue monthly contact with the participant and report the participant’s status. The suspended participant will be reactivated or re-enrolled prior to the completion of the MFP period of participation, back into MFP without re-establishing the 90-day institutional requirement.

ⁱⁱ Upon discharge from the inpatient facility, the MFP participant resumes their period of participation for any remaining days up to the maximum of 365 days. No inpatient days are counted toward the total of the 365 days of MFP. MFP field personnel revise the ITP prior to discharge back into the community.

ⁱⁱⁱ When an MFP participant is suspended for 6 months or longer, the participant must be re-evaluated like a ‘new’ participant.

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