DEPARTMENT OF HEALTH
AND HOSPITALS
Aging and Adult Services

# Money Follows the Person (MFP)/My Place LA Form

**Participant's Name:** _____

**SSN:** _____ **Date of Birth**:_____

**Region #**: _____ **Name of SC Agency**: _____

| Questions: | Responses: |
|---|---|
| 1. Type of institution individual transitioned from into the community<br>Nursing facility ……..…01<br>ICF/DD ……..…02 | 01 |
| 2. Actual date of discharge from nursing facility to community | |
| 3. Type of residence the person has moved into from the institution<br>Home owned by participant ……..……..…01<br>Home owned by family member ……..……02<br>Apartment leased by participant, not assisted living ……03<br>Apartment leased by participant, assisted living …….... 04<br>Apartment subsidized ……..……..…05 | |
| 4. Participant lives with family members<br>Yes ……01<br>No……..02 | |
| 5. Vendor Payment Begin Date - III. C. of BHSF Form 142 | |
| 6. Reason participation ended<br>Completed 365 days of participation……..…..01<br>Suspended eligibility…… 02<br>Re-institutionalized……...03<br>Died……..……..…04<br>Moved……05<br>No longer needed services……..……..06<br>Other……..……...07 | |
| 7. If re-institutionalized, reason for re-institutionalization<br>Acute care hospitalization followed by long term rehabilitation ……...01<br>Deterioration in cognitive functioning ……...……..02<br>Deterioration in health ……..……..…….03<br>Deterioration in mental health ……..……..... 04<br>Loss of housing ……..……..05<br>Loss of personal care giver …… 06<br>By request of participant or guardian ……..... ...07<br>Lack of sufficient community services ….....…….....…08 | |

**Name of SC or SC Supervisor (Please print):**_____

**Signature of SC or SC Supervisor:** _____**Date:**_____

**Instructions:**

This form needs to be completed by the support coordinator (SCs) or support coordinator supervisor on **ALL participants signed up for Money Follows the Person (MFP)/My Place Louisiana.**

**Initial Approvals:**

On the actual date of discharge from the nursing facility into the community, the following must be completed:

- Participant's Name;
- Social Security Number (SSN) and Date of Birth;
- Region #;
- Name of SC Agency;
- Questions 2, 3, 4 and 5; and
- Name and signature of SC or SC Supervisor and date completed

Completed form will be emailed to:

- SRI at MFP@statres.com;
- Celeste Henley at Celeste.Henley@la.gov;
- Donna Thompson at Donna.Thompson2@la.gov; and
- OAAS Regional Office (R.O.) (Along with a copy of the plan of care (POC) identified pages.)

**Re-institutionalizations:**

On the same day that the SCA is notified that the participant is re-institutionalized, the following must be completed:

- Participant's Name,
- Social Security Number (SSN) and Date of Birth;
- Region #;
- Name of SC Agency;
- Question 6 and 7; and
- Name and signature of SC or SC Supervisor and date completed

Completed form will be emailed to:

- SRI at MFP@statres.com;
- Celeste Henley at Celeste.Henley@la.gov;
- Donna Thompson at Donna.Thompson2@la.gov; and
- OAAS Regional Office (R.O.) (Along with a copy of the plan of care (POC) identified pages.)

**Closures/Discharges:**

On the same day that the SC is notified that the participant's case is closed/discharged, the following must be completed:

- Participant's Name;
- Social Security Number (SSN);
- Region #;
- Name of SC Agency;
- Question 6; and
- Name and signature of SC or SC Supervisor and date completed

Completed form will be emailed to:

- SRI at MFP@statres.com;
- Celeste Henley at Celeste.Henley@la.gov;
- Donna Thompson at Donna.Thompson2@la.gov; and
- OAAS Regional Office (R.O.)