MFP 101

Outline and Timeline

MFP 101

- MFP Program Overview
- Timeline
- Forms
  - Referral
  - MFP Information Release
  - Referral Processing
  - Informed Consent
  - Media Release

MFP Program Overview

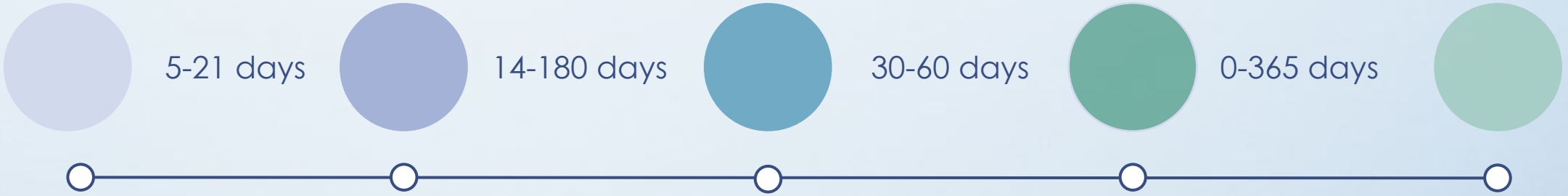
Individuals can sign up for MFP transition assistance if they are:

- eligible for Choices for Care Long Term Care Medicaid, determined via a Notice of Decision or budget approval;
- currently residing in a skilled nursing or acute care facility and have been for at least 60 consecutive days;
- and discharging to a qualified home and community-based residence.

Transition assistance includes:

- Transition Coordination
- Monthly Follow-up Calls
- $2,500 in flexible funding for transition needs

MFP Timeline



Referral

- Referral received by office, ideally 30+ days prior to discharge.
- Referral reviewed and Transition Coordinator assigned.
- Eligibility determined; and any additional paperwork completed.

Enrollment

- Transition Coordinator and Case Manager educate the potential participant.
- Transition Coordinator and Case Manager complete paperwork with client.
- Transition Coordinator touches base with Case Manager and client regularly to assist with discharge planning.

Transition Assistance

- Transition Coordinator provides transition assistance for active enrollees for up to 150 days
- At 120 days, Transition Coordinator evaluates if the individual will be transitioning within the next 30-60 days
- Transition Coordinator notifies office if there is no active discharge in sight

Transition Follow Up

- Transition Coordinator provides regular monthly calls and follow-ups.
- Transition Coordinator provides client and case manager with assistance where needed.

Disenrollment

- If no active discharge plan after 150 days of enrollment, client may be disenrolled.
- Client will be disenrolled if no longer eligible.
- Client and Case Manager will be notified.
- Otherwise, client will remain on MFP until their MFP end date.

MFP Timeline: When do I refer?

- Referrals to MFP should be made as early as possible (up to 180 days) before transition once you know a person has a transition in mind and a place to go.
  - Example: Jane Doe would like to leave the nursing home and return to her home, which needs some modifications. Refer her right now!
  - Example: John Smith would like to leave the hospital and live in an AFC. An agency is willing to take him on, but they have no open homes. Wait until there are some home options!
- Fact: being enrolled in MFP at least 2 weeks before transition increases the success rate of the transition by more than 10% compared to being enrolled for less than two weeks before transition.
- Refer early, refer often! We can always tell you if they're not eligible or if someone has already referred.

MFP Timeline: When don't I refer?

Don't refer to MFP if:

- The person isn't eligible for Choices for Care Vermont Long Term Medicaid.
- The person has already discharged and been living in the community.

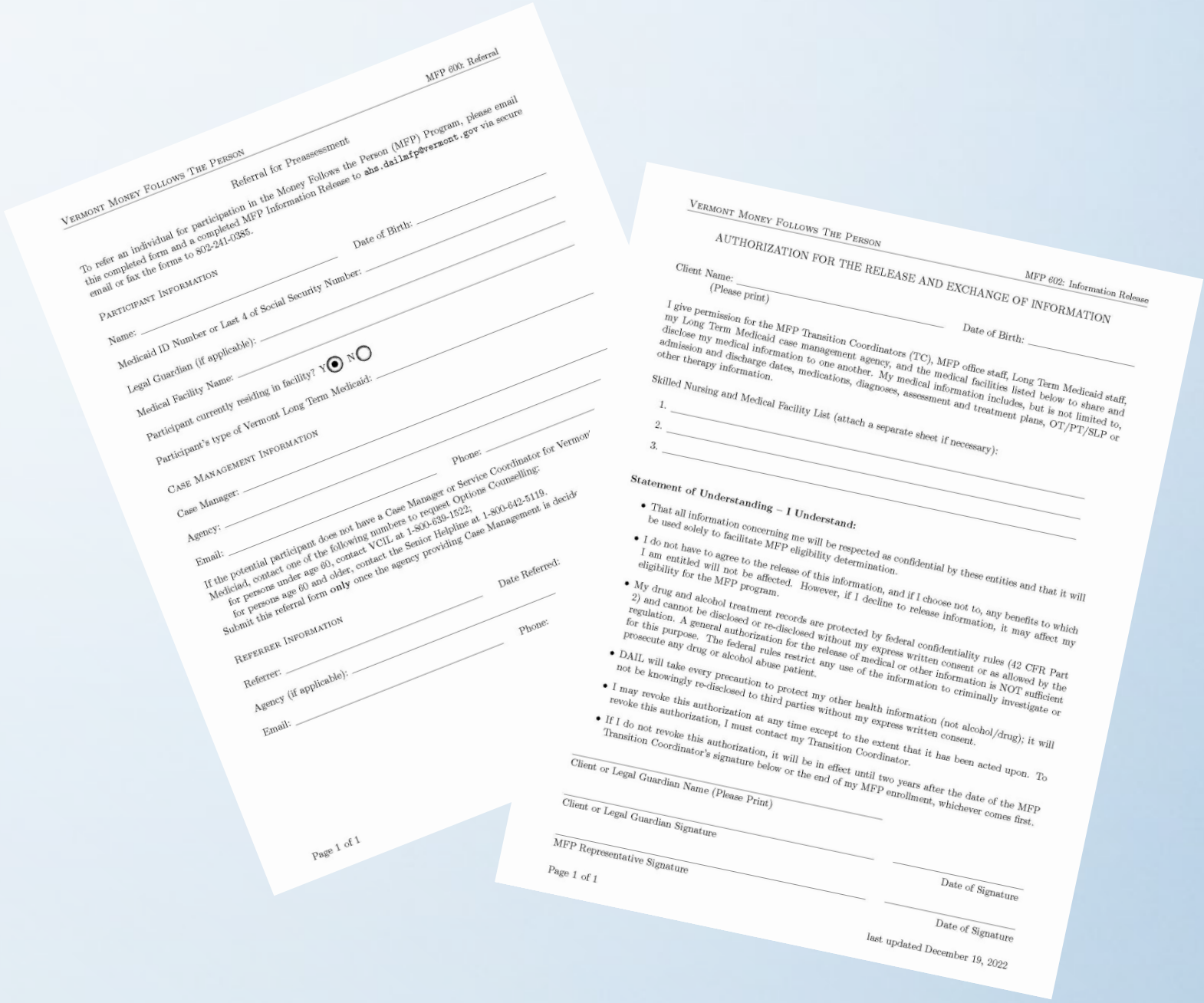
MFP 101

Forms and Processing

MFP Referral

To make a program referral:

- Complete the MFP 600 referral form
- Complete (with Client) the MFP 601 informed consent form for initial eligibility
- Referral source: Social Workers, Case Management Agencies and Long-Term Care Clinical Coordinators
- Referrals are submitted directly to the MFP Program Office



VERMONT MONEY FOLLOWS THE PERSON

MFP 600: Referral

Referral for Preassessment

To refer an individual for participation in the Money Follows the Person (MFP) Program, please email this completed form and a completed MFP Information Release to **ahs.dailmfp@vermont.gov** via secure email or fax the forms to 802-241-0385.

PARTICIPANT INFORMATION

Name: Date of Birth:

Medicaid ID Number or Last 4 of Social Security Number:

Legal Guardian (if applicable):

Medical Facility Name:

Participant currently residing in facility? Y ◉ N ○

Participant's type of Vermont Long Term Medicaid:

CASE MANAGEMENT INFORMATION

Case Manager: Phone:

Agency:

Email:

If the potential participant does not have a Case Manager or Service Coordinator for Vermont Medicaid, contact one of the following numbers to request Options Counselling:
for persons under age 60, contact VCIL at 1-800-639-1522;
for persons age 60 and older, contact the Senior Helpline at 1-800-642-5119.
Submit this referral form **only** once the agency providing Case Management is decide

REFERRER INFORMATION

Referrer: Date Referred:

Agency (if applicable): Phone:

Email:

Page 1 of 1

VERMONT MONEY FOLLOWS THE PERSON

MFP 602: Information Release

AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION

Client Name: Date of Birth:
(Please print)

I give permission for the MFP Transition Coordinators (TC), MFP office staff, Long Term Medicaid staff, my Long Term Medicaid case management agency, and the medical facilities listed below to share and disclose my medical information to one another. My medical information includes, but is not limited to, admission and discharge dates, medications, diagnoses, assessment and treatment plans, OT/PT/SLP or other therapy information.

Skilled Nursing and Medical Facility List (attach a separate sheet if necessary):

1.
2.
3.

Statement of Understanding – I Understand:

- That all information concerning me will be respected as confidential by these entities and that it will be used solely to facilitate MFP eligibility determination.
- I do not have to agree to the release of this information, and if I choose not to, any benefits to which I am entitled will not be affected. However, if I decline to release information, it may affect my eligibility for the MFP program.
- My drug and alcohol treatment records are protected by federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient.
- DAIL will take every precaution to protect my other health information (not alcohol/drug); it will not be knowingly re-disclosed to third parties without my express written consent.
- I may revoke this authorization at any time except to the extent that it has been acted upon. To revoke this authorization, I must contact my Transition Coordinator.
- If I do not revoke this authorization, it will be in effect until two years after the date of the MFP Transition Coordinator's signature below or the end of my MFP enrollment, whichever comes first.

Client or Legal Guardian Name (Please Print)

Client or Legal Guardian Signature Date of Signature

MFP Representative Signature Date of Signature

Page 1 of 1

last updated December 19, 2022

MFP Referral Form

- Individuals referred to the MFP Program must be actively working with a Case Management Agency
- Follow instructions provided if individual does not have a Case Management Agency

Referral for Preassessment

To refer an individual for participation in the Money Follows the Person (MFP) Program, please email this completed form and a completed MFP Information Release to ahs.dailmfp@vermont.gov via secure email or fax the forms to 802-241-0385.

Participant Information

Name: _____ Date of Birth: _____

Medicaid ID Number or Last 4 of Social Security Number: _____

Legal Guardian (if applicable): _____

Medical Facility Name: _____

Participant currently residing in facility? Y◉ N○

Participant's type of Vermont Long Term Medicaid: _____

Case Management Information

Case Manager: _____

Agency: _____

Email: _____ Phone: _____

If the potential participant does not have a Case Manager or Service Coordinator for Vermont Long Term Mediciad, contact one of the following numbers to request Options Counselling:
for persons under age 60, contact VCIL at 1-800-639-1522;
for persons age 60 and older, contact the Senior Helpline at 1-800-642-5119.
Submit this referral form **only** once the agency providing Case Management is decided.

Referrer Information

Referrer: _____ Date Referred: _____

Agency (if applicable): _____

Email: _____ Phone: _____

MFP Information Release

- An information release is required to complete MFP initial eligibility check
- Completed by referrer and client and submitted with referral for eligibility
- If not finished during the referral, the MFP Transition Coordinator will complete with client before eligibility is confirmed.

AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF INFORMATION

Client Name: _____ Date of Birth: _____
(Please print)

I give permission for the MFP Transition Coordinators (TC), MFP office staff, Long Term Medicaid staff, my Long Term Medicaid case management agency, and the medical facilities listed below to share and disclose my medical information to one another. My medical information includes, but is not limited to, admission and discharge dates, medications, diagnoses, assessment and treatment plans, OT/PT/SLP or other therapy information.

Skilled Nursing and Medical Facility List (attach a separate sheet if necessary):

1. _____
2. _____
3. _____

Statement of Understanding – I Understand:

- That all information concerning me will be respected as confidential by these entities and that it will be used solely to facilitate MFP eligibility determination.
- I do not have to agree to the release of this information, and if I choose not to, any benefits to which I am entitled will not be affected. However, if I decline to release information, it may affect my eligibility for the MFP program.
- My drug and alcohol treatment records are protected by federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient.
- DAIL will take every precaution to protect my other health information (not alcohol/drug); it will not be knowingly re-disclosed to third parties without my express written consent.
- I may revoke this authorization at any time except to the extent that it has been acted upon. To revoke this authorization, I must contact my Transition Coordinator.
- If I do not revoke this authorization, it will be in effect until two years after the date of the MFP Transition Coordinator's signature below or the end of my MFP enrollment, whichever comes first.

_____
Client or Legal Guardian Name (Please Print)

_____ _____
Client or Legal Guardian Signature Date of Signature

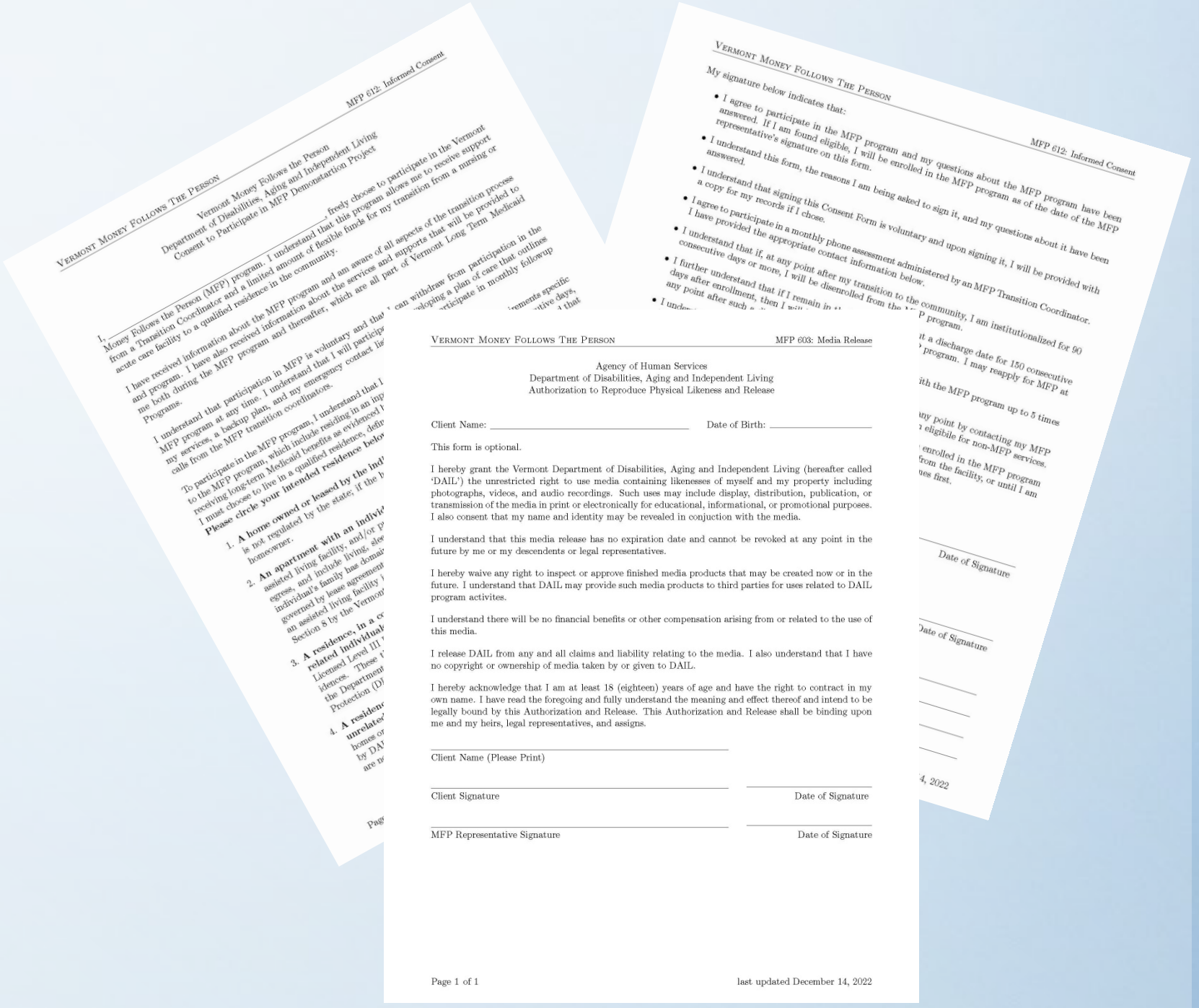
_____ _____
MFP Representative Signature Date of Signature

MFP Referral Processing

- Referral is reviewed for completeness by the MFP office staff.
- Incomplete forms will be returned to the referrer for completion.
- Initial eligibility check is completed by MFP office staff. (Please note: MFP eligibility is monitored throughout enrollment.)
- Office staff assigns a Transition Coordinator.
- Office staff notifies the Transition Coordinator and Case Management Agency of referral status.
- Transition Coordinator contacts Case Management Agency/Case Manager to continue MFP processing.

MFP Education and Enrollment

- MFP Transition Coordinators arrange initial MFP Program education in conjunction with Case Managers
- MFP Transition Coordinator and/or Case Manager reviews additional paperwork with individual for enrollment



VERMONT MONEY FOLLOWS THE PERSON — MFP 603: Media Release

Agency of Human Services
Department of Disabilities, Aging and Independent Living
Authorization to Reproduce Physical Likeness and Release

Client Name: _____ Date of Birth: _____

This form is optional.

I hereby grant the Vermont Department of Disabilities, Aging and Independent Living (hereafter called 'DAIL') the unrestricted right to use media containing likenesses of myself and my property including photographs, videos, and audio recordings. Such uses may include display, distribution, publication, or transmission of the media in print or electronically for educational, informational, or promotional purposes. I also consent that my name and identity may be revealed in conjuction with the media.

I understand that this media release has no expiration date and cannot be revoked at any point in the future by me or my descendents or legal representatives.

I hereby waive any right to inspect or approve finished media products that may be created now or in the future. I understand that DAIL may provide such media products to third parties for uses related to DAIL program activites.

I understand there will be no financial benefits or other compensation arising from or related to the use of this media.

I release DAIL from any and all claims and liability relating to the media. I also understand that I have no copyright or ownership of media taken by or given to DAIL.

I hereby acknowledge that I am at least 18 (eighteen) years of age and have the right to contract in my own name. I have read the foregoing and fully understand the meaning and effect thereof and intend to be legally bound by this Authorization and Release. This Authorization and Release shall be binding upon me and my heirs, legal representatives, and assigns.

_____
Client Name (Please Print)

_____ _____
Client Signature Date of Signature

_____ _____
MFP Representative Signature Date of Signature

Page 1 of 1 last updated December 14, 2022

MFP Informed Consent

- The informed consent is the official enrollment document for the MFP program
- Enrollment start date for MFP Transition Services is the date the Informed Consent Form is signed by the Transition Coordinator
- Eligibility is continually monitored, and the individual must maintain eligibility throughout program enrollment
- Eligibility is monitored by office staff. Questions regarding eligibility can be sent to the MFP email address

MFP 612 – Informed Consent Form

Vermont Money Follows the Person
Department of Disabilities, Aging and Independent Living
Consent to Participate in MFP Demonstartion Project

I, _____, freely choose to participate in the Vermont Money Follows the Person (MFP) program. I understand that this program allows me to receive support from a Transition Coordinator and a limited amount of flexible funds for my transition from a nursing or acute care facility to a qualified residence in the community.

I have received information about the MFP program and am aware of all aspects of the transition process and program. I have also received information about the services and supports that will be provided to me both during the MFP program and thereafter, which are all part of Vermont Long Term Medicaid Programs.

I understand that participation in MFP is voluntary and that I can withdraw from participation in the MFP program at any time. I understand that I will participate in developing a plan of care that outlines my services, a backup plan, and my emergency contact list. I will also participate in monthly followup calls from the MFP transition coordinators.

To participate in the MFP program, I understand that I must meet all of the eligibility requirements specific to the MFP program, which include residing in an inpatient facility for at least sixty (60) consecutive days, receiving long-term Medicaid benefits as evidenced by a Long Term Medicaid Notice of Decision, and that I must choose to live in a qualified residence, defined as:
Please circle your intended residence below

1. **A home owned or leased by the individual or the individual's family member.** This option is not regulated by the state; if the home is leased, the lease is entered into with the landlord or homeowner.
2. **An apartment with an individual lease.** This residence type can be in an apartment building, assisted living facility, and/or public housing unit. The apartment must have lockable access and egress, and include living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control. Apartments in privately-owned apartment buildings are governed by lease agreements entered into with the landlord or building owner. An apartment within an assisted living facility is regulated by the state, and public housing units are regulated through Section 8 by the Vermont State Housing Authority.
3. **A residence, in a community-based residential setting, in which no more than four unrelated individuals reside.** These types of community-based settings can include: group homes, Licensed Level III Residential Care (including enhanced residential care), and Assisted Living Residences. These three types of community based alternative residential settings are regulated by the Department of Disabilities, Aging and Independent Living (DAIL), Division of Licensing and Protection (DLP).
4. **A residence, in a community-based residential setting, in which one or two individuals unrelated to the owner or leasholder reside.** These residence types are Adult Family Care homes or Shared Living Providers. They are required to meet health and safety standards established by DAIL and are monitored regularly by Community Development staff and case managers. They are not, however, formally licensed by DAIL's DLP.

My signature below indicates that:

- I agree to participate in the MFP program and my questions about the MFP program have been answered. If I am found eligible, I will be enrolled in the MFP program as of the date of the MFP representative's signature on this form.
- I understand this form, the reasons I am being asked to sign it, and my questions about it have been answered.
- I understand that signing this Consent Form is voluntary and upon signing it, I will be provided with a copy for my records if I chose.
- I agree to participate in a monthly phone assessment administered by an MFP Transition Coordinator. I have provided the appropriate contact information below.
- I understand that if, at any point after my transition to the community, I am institutionalized for 90 consecutive days or more, I will be disenrolled from the MFP program.
- I further understand that if I remain in the institution without a discharge date for 150 consecutive days after enrollment, then I will be disenrolled from the MFP program. I may reapply for MFP at any point after such a disenrollment.
- I understand that I may qualify to transition to the community with the MFP program up to 5 times in my lifetime.
- I understand that I may withdraw my participation from MFP at any point by contacting my MFP Transition Coordinator. Upon withdrawing from MFP, I will remain eligibile for non-MFP services.
- If I do not withdraw my consent to participate in MFP, I will remain enrolled in the MFP program until I have resided in the community for 365 days after transitioning from the facility, or until I am no longer eligible for or otherwise disenrolled from MFP, whichever comes first.

_____
Client or Legal Guardian Name (Please Print)

_____ _____
Client or Legal Guardian Signature Date of Signature

_____
MFP Representative Name (Please Print)

_____ _____
MFP Representative Signature Date of Signature

Monthly Follow-up Assessment Contact Information:

Primary Contact: _____

Primary Contact Phone: _____ Primary Contact Phone #2: _____

Secondary Contact (optional): _____ Relationship: _____

Secondary Contact Phone: _____ Secondary Contact Phone #2: _____

MFP Media Release

- This is an optional document for program enrollees
- MFP is a federal demonstration program
- An important part of the demonstration is sharing successes and challenges of program participants
- Photos and personal stories provide important feedback for educational purposes

Agency of Human Services
Department of Disabilities, Aging and Independent Living
Authorization to Reproduce Physical Likeness and Release

Client Name: _____ Date of Birth: _____

This form is optional.

I hereby grant the Vermont Department of Disabilities, Aging and Independent Living (hereafter called 'DAIL') the unrestricted right to use media containing likenesses of myself and my property including photographs, videos, and audio recordings. Such uses may include display, distribution, publication, or transmission of the media in print or electronically for educational, informational, or promotional purposes. I also consent that my name and identity may be revealed in conjuction with the media.

I understand that this media release has no expiration date and cannot be revoked at any point in the future by me or my descendents or legal representatives.

I hereby waive any right to inspect or approve finished media products that may be created now or in the future. I understand that DAIL may provide such media products to third parties for uses related to DAIL program activites.

I understand there will be no financial benefits or other compensation arising from or related to the use of this media.

I release DAIL from any and all claims and liability relating to the media. I also understand that I have no copyright or ownership of media taken by or given to DAIL.

I hereby acknowledge that I am at least 18 (eighteen) years of age and have the right to contract in my own name. I have read the foregoing and fully understand the meaning and effect thereof and intend to be legally bound by this Authorization and Release. This Authorization and Release shall be binding upon me and my heirs, legal representatives, and assigns.

_____
Client Name (Please Print)

_____ _____
Client Signature Date of Signature

_____ _____
MFP Representative Signature Date of Signature

ahs.dailmfp@vermont.gov

Questions