

MONEY FOLLOWS THE PERSON

PROFESSIONAL RECOMMENDATION

| |
|---|
| Applicant's Name: _____ SSN#: _____ |
| Representative Name: _____ Title: _____ |
| Contact Information (Phone and Email): _____ |

Referral is:

- | | |
|--|---|
| <input type="checkbox"/> Appropriate for MFP | <input type="checkbox"/> Inappropriate for MFP |
| <input type="checkbox"/> With Waiver <input type="checkbox"/> Without Waiver | |
| <input type="checkbox"/> Community housing sufficient | <input type="checkbox"/> Ongoing extreme threat for harm to others/self |
| <input type="checkbox"/> Supportive family members/friends | <input type="checkbox"/> Required services not available in community- |
| <input type="checkbox"/> Medical needs can be met | <input type="checkbox"/> Requires continual 24hr skilled care |
| <input type="checkbox"/> Own responsible party | <input type="checkbox"/> POA/Guardian refuses to consent |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Additional Comments:

Representative Signature

Date