

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES**

MFP Demonstration Services - START SERVICES FORM

PLEASE RETURN THIS FORM TO THE MONEY FOLLOWS THE PERSON TRANSITION COORDINATOR WITHIN 3 WORKING DAYS OF STARTING SERVICES. IF THERE HAVE BEEN ANY CHANGES IN SERVICES OR IF SERVICES HAVE BEEN DISCONTINUED, THE MFP TRANSITION COORDINATOR MUST BE NOTIFIED VIA DHS-8504 FORM IMMEDIATELY.

SECTION I - TO BE COMPLETED BY THE MFP TRANSITION COORDINATOR

TO: _____

DATE: Mailed to Provider(s)/Client _____ Co. of Residence _____

FROM: Money Follows the Person _____

RE: Client's Name _____
 Client's SS# or Medicaid # _____

SECTION II - TO BE COMPLETED BY THE MFP DEMONSTRATION SERVICES PROVIDER

PLEASE CIRCLE ONE OF THE FOLLOWING: Date Service Began, Date Service Changed or Date Service Continues.

DEMONSTRATION SERVICES: (Enter a DATE only when indicating a "Began" or "Changed" service.)

Service	Date	Began/Changed	Units per Week
24 Hour Helpline			
In Home Monitoring			
Telemedicine			
Community Transition Services			
Supported Living			
24 Hour Attendant Care			
Intense Transition Management			
Therapeutic Intervention			

Attendant/Waiver Provider Name _____

Name/Title of Person Completing Form _____