



Missouri Long-Term Care Ombudsman Program
MONEY FOLLOWS THE PERSON DEMONSTRATION (MFP) REFERRAL

FAX TO: SHOMARI ROZIER 573.522.4888	
FROM (PLEASE PRINT OR TYPE):	FAX:
PHONE:	DATE:
REFERRAL (COMPLETED BY REGIONAL LTCOP COORDINATOR)	
FACILITY NAME & ADDRESS:	FACILITY TELEPHONE:
RESIDENT'S NAME:	RESIDENT'S DATE OF BIRTH:
RESIDENT'S CONDITION: (ATTACH ANOTHER SHEET IF NEEDED)	RESIDENT'S SSN:
	RESIDENT'S DCN:
	DATE ENTERED SNF:
DISPOSITION (NOTIFY MFP OVERSIGHT STAFF WITHIN 30 DAYS)	
<input type="checkbox"/> RESIDENT APPROVED FOR MFP	DATE OF ENROLLMENT:
<input type="checkbox"/> RESIDENT DOES NOT MEET ELIGIBILITY REQUIREMENTS - CHECK ALL THAT APPLY. <ul style="list-style-type: none"> <input type="checkbox"/> NOT MEDICAID ELIGIBLE <input type="checkbox"/> NO QUALIFIED HOUSING AVAILABLE <input type="checkbox"/> GUARDIAN REFUSED PARTICIPATION <input type="checkbox"/> RESIDENT NOT IN SKILLED NURSING FACILITY (SNF) FOR 90 DAYS <input type="checkbox"/> RESIDENT QUALIFIED BUT NOT APPROVED DUE TO HEALTH AND SAFETY CONCERNS <input type="checkbox"/> RESIDENT IN SNF SOLELY FOR THE PURPOSE OF SHORT-TERM REHABILITATION FUNDED BY MEDICARE 	
<input type="checkbox"/> RESIDENT DOES NOT MEET LEVEL OF CARE FOR HOME AND COMMUNITY BASED SERVICES	
MFP/RC NAME:	PHONE:
COMMENTS (COMMUNITY SUPPORTS, CHALLENGES, ETC.)	
CHECK BOX IF ADDITIONAL PAGES ATTACHED <input type="checkbox"/>	