Money Follows the Person Referral Information

Please complete this form electronically and send to Lindsey Robertson at lrobert1@dhs.state.ia.us.

Consumer Information

Consumer's full legal name:	Social security number:
DOB:	State identification number:
Address:	Current facility and contact information:
Race/Ethnicity (for statistical purposes only):	Date of admission to facility (mm/dd/yy):
Current diagnoses (must have Intellectual Disability* or Brain Injury diagnosis to qualify for this program):	
Name of current managed care organization:	Name of MCO case manager (or note if Fee-For-Service):
In what community or area of the state would the consumer like to live:	

Referral Information

Date of referral:	Referral made by:
Phone number:	Email address:
Relationship to consumer:	

Legal Guardian Information

Guardian name (if applicable):	Address:
Phone number:	Email address:

Is the guardian aware of the referral to MFP? ☐ Yes ☐ No

Do you have a release for MFP signed by the guardian? ☐ Yes ☐ No

Do you have a copy of the guardianship papers? ☐ Yes ☐ No

Relationship to consumer:

Other Important Team and Family Members

Name and relationship:	Name and relationship:
Phone #:	Phone #:
Email:	Email:

Additional Information – Please do not leave blank.

Have referrals been made to providers? ☐ Yes ☐ No

If yes, please list the providers and contact information:

Is a move date already established? ☐ Yes ☐ No

Does the consumer have a current behavioral support plan? ☐ Yes ☐ No

Please list any preferences or specific needs for the living environment:

Other relevant information:

*if person referred has an Intellectual Disability, send documentation of eligibility consistent with Iowa Code 441—83.61(249A)