IOWA Health and Human Services

Money Follows the Person (MFP) Referral Information

Please complete this form electronically and send to the MFP Inbox at mfpcentral@hhs.iowa.gov.

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)