MONEY FOLLOWS THE PERSON
DEMONSTRATION PROJECT

Transition Process Detail

1. Confirming Interest in Transitioning Under MFP

Facility resident indicates interest in MFP

2. Applying for MFP

ANYONE may submit an application on the resident's behalf

3. Securing Approval

MFP project staff approves MFP application and informs transition coordination entity

4. Getting Ready

If it hasn't already started, Transition Coordinator prepares to begin process:

1. Gets to know person/family informally
2. Briefs appropriate colleagues within transition agency
3. Becomes familiar with other transition team members (facility social worker, etc.)

5. First Required Transition Meeting

Begin completing MFP Transition Plan

Additional transition planning meetings, conversations and phone calls as needed

During this time, 1) secure services
2) train staff 3) conduct clinical consultations
4) develop MFP transition plan
5) finalize care plan/service plan/
Person-Centered Planning

6. Required Final Transition Planning Meeting

- Confirming everyone is "on board" and understands what will happen after the transition
- Finalize MFP Transition Plan

7. Final Transition Details

- MFP Quality of Life Survey
- MFP Pre-transition Briefing
- Finalize Service Planning

Post Follow Along Details

1) Notify MFP
2) Finalize Transition Checklist
3) Begin Follow Along Visit Schedule
Transition Coordinator/Care Coordinator Available, Services Begin Day one
Staff have been trained

Follow Along as Needed and as Required

THREE MONTHS ——— ONE YEAR

MFP PARTICIPATION ENDS
No impact on waiver services

MFP Overview

Person in Inpatient Facility

- Hospital
- Skilled nursing facility
- Intermediate care facility

For at Least Three Months

- Medicare considerations

Medicaid Eligible

- Mindful of deductible status

Transition Process

- Community Alternatives Program slot or All-Inclusive Care for the Elderly
- Transition year stability resources
- Enhanced case management
- Transition coordination

Moves Back into Own Home and Community

- Own house or apartment
- Family's home
- Group home of four people or fewer*

  * For people with I/DD only in NC

Objectives:

- Increase the use of home and community-based, rather than institutional, long-tem care services
- Eliminate barriers or mechanisms, whether in state law, the state Medicaid plan, the state budget, or other obstacles which prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice
- Increase the ability of the state Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting
- Ensure strategies and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement for such services

Website: http://bit.ly/moneyfollowstheperson

Medical Assistance
HEALTH AND HUMAN SERVICES

State of North Carolina • Department of Health and Human Services • Division of Medical Assistance
www.ncdhhs.gov • http://bit.ly/moneyfollowstheperson

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