



Money Follows the Person Referral Information

Please complete this form electronically and send to Brooke Lovelace at blovela@dhs.state.ia.us.

Consumer Information	
Consumer's full legal name:	Social security number:
DOB:	State identification number:
Address:	Current provider and contact information:
Race/Ethnicity (for statistical purposes only):	Date of admission to facility:
Current diagnoses:	
Name of current managed care organization:	Name of current community-based case manager:
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a release for MFP signed by the guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a copy of the guardianship papers?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list the providers and contact information:	
Is a move date already established?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the consumer have a current behavioral support plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any preferences or specific needs for the living environment:	
Other relative information:	