MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI DEPARTMENT OF MENTAL HEALTH
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

MONEY FOLLOWS THE PERSON PARTICIPATION AGREEMENT

PARTICIPANT NAME	
MO HEALTHNET NUMBER	COUNTY OF RESIDENCE

SUMMARY

The Money Follows the Person Demonstration is designed to assist individuals who wish to transition from institutions into the community. The Money Follows the Person Demonstration's intent is to eliminate barriers to receiving services and to ensure delivery of quality services.

AGREEMENT

I understand that I must be eligible for MO HealthNet in order to participate in the Money Follows the Person Demonstration.

I understand that my participation in the Money Follows the Person Demonstration is for a period of one year from the date of my transition into the community. My home and community based services will continue uninterrupted and without reduction following the demonstration period, as long as there is a continued need and all eligibility requirements are met.

I understand that the Federal Government will pay for a larger portion of my home and community based services during the one year that I participate in the demonstration.

I understand that any HCBS MFP demonstration services I receive to aid in transition, such as utility deposits or home modifications, are not ongoing and will terminate after my year of participation in the demonstration.

I agree to participate in the Money Follows the Person Demonstration. I understand there will be ongoing surveys and follow-up regarding my transition into the community. I understand that I am encouraged, but not required, to participate in the survey that will help demonstrate the success of the project.

I understand that I have the right to end my participation in the demonstration at any time during the one year period.

I have reviewed this form and understand that my signature acknowledges agreement in participation in the Money Follows the Person Demonstration.

I understand that the Federal and State laws will be followed regarding the sharing of my personal health information.

I agree to participate in the Money Follows the Person Demonstration requirements as set forth herein.

PARTICIPANT	DATE

As guardian, I agree to facilitate successful participation of _____ in the Money Follows the Person Demonstration.

GUARDIAN SIGNATURE	DATE

If at any time you have questions call Department of Health and Senior Services Information Hotline: 800-235-5503 or Department of Mental Health: 800-364-9687.