MONEY FOLLOWS THE PERSON PARTICIPATION AGREEMENT	
PARTICIPANT NAME	
MO HEALTHNET NUMBER	COUNTY OF RESIDENCE
SUMMARY	
,	assist individuals who wish to transition from institutions into on's intent is to eliminate barriers to receiving services and to
AGREEMENT	
Demonstration.  I understand that my participation in the Money Follows the F	in order to participate in the Money Follows the Person Person Demonstration is for a period of one year from the date unity based services will continue uninterrupted and without
reduction following the demonstration period, as long as ther I understand that the Federal Government will pay for a larg	e is a continued need and all eligibility requirements are met.  er 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 modifications, are not ongoing and will terminate after my ye	receive to aid in transition, such as utility deposits or home ar of participation in the demonstration.
	monstration. I understand there will be ongoing surveys and stand that I am encouraged, but not required, to participate in ect.
I understand that I have the right to end my participation in the	ne demonstration at any time during the one year period.
I have reviewed this form and understand that my signature a the Person Demonstration.	cknowledges agreement in participation in the Money Follows
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 Demo	onstration 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.