Money Follows the Person (MFP)

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DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

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What is MFP?

Money Follows the Person is a federal initiative launched in 2005. The program was born out of the principles established in the 1999 Supreme Court case Olmstead v. L., C.

In this landmark decision, the Court ruled that unnecessarily institutionalizing individuals with disabilities violates the American with Disabilities Act (ADA).

The ruling emphasized that people with disabilities have the right to receive care in the least restrictive setting appropriate for their needs. Often this means in their own homes in their communities.

MFP operationalizes the Olmstead decision by providing states with the tools and funding to help individuals transition from institutions to community-based living.

MFP is Olmstead in action.

MFP Introduction

Nationally, approximately 44 states participate in MFP resulting in over 127,000 individuals moving back into their communities from institutional settings.

Since its inception in 2014, Montana's Senior and Long-Term Care Division (SLTCD) has overseen the MFP Demonstration Project, facilitating the transition of approximately 340 individuals from institutional environments to more independent, community-based settings.

The project provides flexible funding to support seniors and individuals with disabilities in transitioning from nursing homes and hospitals to community-based living.

Montana MFP offers:

Transition coordination	Demonstration services	Supplemental services

The MFP Vision

Reduce	Reduce reliance on institutional care.
Develop	Develop community-based, long-term care opportunities.
Promote	Promote community-based living to improve the well-being of elderly or disabled Montanans.
Enact	Enact procedures to improve home and community-based services.
Create	Create initiatives to increase home and community-based capacity.

MFP Eligibility

Who is eligible for MFP funding?

- Medicaid members who have resided in an institutional setting for 60 or more consecutive days.
  - One of those days must be paid for by Medicaid.
  - Institutional settings = inpatient hospital, inpatient rehabilitation facility, skilled nursing facility.
- Members who meet the eligibility criteria of one of the Montana waiver programs.
  - Big Sky Waiver (BSW)
  - Severe Disabling Mental Illness (SDMI)
  - Developmental Disabilities (DD)
- Members who are willing to move into an MFP-qualified setting based on the person-centered plan.
  - Home or apartment owned by the individual or their family member.
  - Community-based residential setting with no more than four unrelated residents (group home).
  - Assisted Living Facility that:
    - Provides a lease;
    - Provides the participant with living, sleeping, bathing, and cooking areas, over which they have domain and control;
    - Has lockable access and egress;
    - Does not require the participant to notify the facility of absences; and
    - Provides the participants with the ability to refuse a change in apartment or roommate.

Benefits of MFP Funding

Transition Coordination

- The coordination team can consist of the individual, family members, existing case managers, social workers, nursing staff, and others involved in facilitating transitions.
- The regional transition coordinator oversees all aspects of the move.

Demonstration Services and Supplemental Services

- Environmental and vehicle modifications.
- Deposits (rent/utilities).
- Past-due credit that impacts the ability to obtain housing.
- Limited furnishings.

Regional Transition Coordinators

A transition coordinator plays a crucial role in ensuring a smooth and successful transition for individuals moving from an institutional setting back into the community. Here are some key reasons why they are needed.

- Personalized Planning: Transition coordinators work closely with individuals to develop a personalized transition plan that addresses their individual needs, preferences and goals. This includes identifying suitable housing, arranging necessary medical equipment, and coordinating home care services.
- Resource coordination: Transition coordinators help connect individuals with various community resources and services, such as transportation, peer support, and financial assistance for housing and household goods. This ensures that all necessary supports are in place for a safe and successful transition.
- Advocacy and support: Transition coordinators advocate for the individual's needs and preferences, ensuring their voice is heard throughout the process. They provide emotional support and guidance, helping individual navigate the complexities of transitioning back to the community.

Supplemental Services

Clothing Grant: Enables MFP participants to acquire essential clothing aimed at facilitating their community integration.

Pantry Stock: This allows participants to obtain a baseline of nutritional needs for when they arrive in their new home. The pantry stock ensures participants' nutritional needs are met upon moving. Food banks, while an important resource, are not available in all areas of the state. All MFP participants are encouraged to apply for SNAP benefits after moving into the community.

Occupational Therapist Assessment: A home visit to be scheduled while living in the institutional setting to assess for safety needs and identify needed modifications to increase independence and safety.

Specialized Equipment: The Nursing Home Transition Assessment form will comprehensively address the needs of MFP participants as they transition to community housing and increased independence, including the requirement for specialized equipment. *see manual for examples

Medical Supplies: The Nursing Home Transition Assessment form will comprehensively address the needs of MFP participants as they transition to community housing and increased independence, including the requirement for medical supplies.

Rental Application Fee(s): Rental application fees often hinder community living opportunities for MFP participants who can retain only $50/month personal needs money.

Security Deposit: Deposits to secure a community-based home which can include first and last month's rent.

Benefits of MFP Funding

Once an individual moves out of an institutional setting and back into community living, MFP covers 365 days of waiver services as well as other associated services based on a person-centered plan.

- Home Health
- Hospice
- Physical Therapy, Occupational Therapy, and Speech Therapy
- Community First Choice Services /Personal Care Services

During the 365 days, MFP monitors the status of each participant.

After the 365 days, qualified services continue based on the individual's needs and program requirements.

Referrals

Anyone can make a referral to MFP

Individuals living in an institutional setting are encouraged to refer themselves.

How to contact MFP

dphhs.mt.gov/SLTC/mfp
Select the Make a Referral tab, and complete the secure form.
Email: MoneyFollowsThePerson@mt.gov
Phone: 406.439.6870
Fax: 406.655.7646

Questions

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