

MFP DEMONSTRATION FINANCIAL FORM a

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

**DEMONSTRATION EXPENDITURES BY TYPE OF SERVICE
FOR THE MONEY FOLLOWS THE PERSON DEMONSTRATION PROGRAM
EXPENDITURES IN QUARTER _____ (ex. Q1-2007 = 1st Quarter of 2007)**

	TOTAL COMPUTABLE	TOTAL STATE SHARE	ENHANCED FMAP			ADJUSTMENTS for PRIOR PERIODS****	TOTAL FEDERAL SHARE
			*Qualified HCBS	**Demonstration Services	***Supplemental Services		
			____%	____%	____%		
	(a)	(b)	(c)'	(d)	(e)	(f)	(g)
I. State Plan Services							
5. CLINIC SERVICES*	\$0	\$0	\$0	\$0	\$0	\$0	\$0
6. TARGETED CASE MANAGEMENT FOR LONG TERM CARE*	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7. PACE* (PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8. REHABILITATION SERVICES*	\$0	\$0	\$0	\$0	\$0	\$0	\$0
9. HOME HEALTH SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$0
10. HOSPICE*	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11. PERSONAL CARE SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$0
12. OPTIONAL MEDICAID PLAN SERVICES* (detail on Form b)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTALS-State Plan Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0
II. Waiver Services	(a)	(b)	(c)'	(d)	(e)	(f)	(g)
1. CASE MANAGEMENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. HOMEMAKER SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3. HOME HEALTH AIDE SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4. PERSONAL CARE	\$0	\$0	\$0	\$0	\$0	\$0	\$0
5. ADULT DAY HEALTH	\$0	\$0	\$0	\$0	\$0	\$0	\$0
6. HABILITATION	\$0	\$0	\$0	\$0	\$0	\$0	\$0
a. RESIDENTIAL HABILITATION	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. DAY HABILITATION	\$0	\$0	\$0	\$0	\$0	\$0	\$0
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))	\$0	\$0	\$0	\$0	\$0	\$0	\$0
a. PREVOCATIONAL SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. SUPPORTED EMPLOYMENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0
c. EDUCATION	\$0	\$0	\$0	\$0	\$0	\$0	\$0
8. RESPITE CARE	\$0	\$0	\$0	\$0	\$0	\$0	\$0
9. DAY TREATMENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0
10. PARTIAL HOSPITALIZATION	\$0	\$0	\$0	\$0	\$0	\$0	\$0
11. PSYCHOSOCIAL REHABILITATION	\$0	\$0	\$0	\$0	\$0	\$0	\$0
12. CLINIC SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$0
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))	\$0	\$0	\$0	\$0	\$0	\$0	\$0
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$0
15. OTHER* (detail on Form b)	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTALS-Waiver Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTALS-Both Waiver & State Plan Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0

* Qualified HCBS Services are statutory HCBS waiver services that will continue once the MFP demonstration has ended

** Demonstration Services are statutory HCBS waiver services that will only be billed during an individual's 12 month transition period.

*** Supplemental services are non-statutory HCBS waiver services that will only be available for the MFP Demonstration period.

MFP DEMONSTRATION FINANCIAL FORM b
Detail for Optional Medicaid State Plan Services & "Other" Waiver Services

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DEMONSTRATION EXPENDITURES BY TYPE OF SERVICE
FOR THE MONEY FOLLOWS THE PERSON DEMONSTRATION PROGRAM
EXPENDITURES IN QUARTER _____ (ex. Q1-2007 = 1st Quarter of 2007)

I. State Plan Services	TOTAL COMPUTABLE	TOTAL STATE SHARE	ENHANCED FMAP		Reg. FMAP	ADJUSTMENTS for PRIOR PERIODS****	TOTAL FEDERAL SHARE
			*Qualified HCBS _____%	**Demonstration Services _____%	***Supplemental Services _____%		
PLAN SERVICES* OPTIONAL MEDICAID (Detail from Form a, Line I,12)	(a)	(b)	(c)'	(d)	(e)	(f)	(g)
a.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
c.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
d.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
e.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
f.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
g.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTALS	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(Detail from Form a, Section II, line 15)	(a)	(b)	(c)'	(d)	(e)	(f)	(g)
a.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
c.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
d.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
e.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
f.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
g.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTALS-Waiver Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTALS-Both Waiver & State Plan Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0

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