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accuracy of the time estimate(s)
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MFP DEMONSTRATION FINANCIAL FORM A

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

D E M O N S T R A T I O N E X P E N D I T U R E S B Y T Y P E O F S E R V I C E
F O R T H E M O N E Y F O L L O W S T H E P E R S O N D E M O N S T R A T I O N P R O G R A M
E X P E N D I T U R E S F O R T H E Q U A R T E R E N D I N G _____(ex: December 31, 2008)

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

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

**** Demonstration Services are services that can be covered under Medicaid that will only be billed during an individuals 12 month transition period.**

***** Supplemental services are services that will only be available for the MFP Demonstration period and are not covered by Medicaid.**

MFP DEMONSTRATION FINANCIAL FORM B

Detail for Optional Medicaid State Plan Services & "Other" Waiver Services

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

D E M O N S T R A T I O N E X P E N D I T U R E S B Y T Y P E O F S E R V I C E
F O R T H E M O N E Y F O L L O W S T H E P E R S O N D E M O N S T R A T I O N P R O G R A M
E X P E N D I T U R E S F O R T H E Q U A R T E R E N D I N G _____(ex: December 31, 2008)

State:	TOTAL COMPUTABLE	TOTAL STATE SHARE	ENHANCED FMAP *Qualified HCBS ____%	ENHANCED FMAP **Demonstration Services ____%	Reg. FMAP ***Supplemental Services ____%	ADJUSTMENTS for PRIOR PERIODS - Qualified HCBS	ADJUSTMENTS for PRIOR PERIODS - Demonstration Services	ADJUSTMENTS for PRIOR PERIODS - Supplemental Services	TOTAL FEDERAL SHARE
I. State Plan Services OPTIONAL MEDICAID PLAN SERVICES* (Detail for Form A, Line I,12)	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
a.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
b.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
c.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
d.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
e.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
TOTALS - Optional Plan Services	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
II. "Other" Services, Demo & Supplemental Services (Detail for Form A, Section II, line 15)	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
a.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
b.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
c.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
d.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
e.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
f.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
g.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
h.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
i.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
j.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
k.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
l.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
m.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
n.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
o.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
p.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
q.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
r.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
s.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
t.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
u.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
TOTALS - "Other" , Demo, & Supplemental Services	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
TOTALS - Optional, "Other" , Demo & Supplemental Services	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

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

**** Demonstration Services are services that can be covered under Medicaid that will only be billed during an individuals 12 month transition period.**

***** Supplemental services are services that will only be available for the MFP Demonstration period and are not covered by Medicaid.**

MFP DEMONSTRATION FINANCIAL FORM C

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 THE QUARTER ENDING _____(ex: December 31, 2008)

State:	TOTAL COMPUTABLE	TOTAL STATE SHARE	ADMINISTRATIVE FMAP				QoL Survey	ADJUSTMENTS for PRIOR PERIODS	TOTAL FEDERAL SHARE
			Normal Rate 50%	SPMP 75%	Enhanced 90%	Other 100%	Reimbursement @$100 per survey		
III. Administrative	(a)	(b)	(c)'	(d)	(e)	(f)	(g)	(h)	(i)
a.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
b.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
c.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
d.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
e.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
f.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
g.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
h.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
i.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
j.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
k.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
l.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
m.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
n.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
o.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
p.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
q.	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
TOTALS	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Administration - Normal should include all costs that adhere to CFR Title 42, Section 433(b)(7)

Administrative Skilled Professional Medical Personnel (SPMP) - 75% should include all costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10)

Administrative Enhanced - 90% should include all costs that adhere to CFR Title 42 Section 433(b)(3)

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

MFP DEMONSTRATION FINANCIAL FORM D

NARRATIVE EXPLANATIONS

STATE

QUARTER ENDING

NARRATIVE