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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 FOR THE QUARTER ENDING _____ (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 continue once the MFP demonstration has ended
 ** Demonstration Services are services that can be covered under Medicaid that will only be billed during an individual's 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

DEMONSTRATION EXPENDITURES BY TYPE OF SERVICE
FOR THE MONEY FOLLOWS THE PERSON DEMONSTRATION PROGRAM
EXPENDITURES FOR THE QUARTER ENDING _____ (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
b.	\$0	\$0	\$0	\$0		\$0	\$0	\$0	\$0
c.	\$0	\$0	\$0	\$0		\$0	\$0	\$0	\$0
d.	\$0	\$0	\$0	\$0		\$0	\$0	\$0	\$0
e.	\$0	\$0	\$0	\$0		\$0	\$0	\$0	\$0
TOTALS - Optional Plan Services	\$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 continue once the MFP demonstration has ended
 ** Demonstration Services are services that can be covered under Medicaid that will only be billed during an individual's 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)

[illegible]