The purpose of this Alert is to remind all Residential Health Care Facilities (RHCFs), Managed Care Plans, Managed Long Term Care Plans and organizations assisting clients applying for Medicaid coverage for nursing home level of care to submit application/conversion/renewal packages for nursing home level of care immediately, even if all income/resource documentation have not been collected. The use of the Asset Verification System (AVS) provides the agency with bank account and real property information. Documentation is only required when information is not available in AVS or for incapacitated individuals that cannot consent to AVS. Submitting the application timely will prevent the loss of a Medicaid pick up date, which can be up to 90 days retroactively from the submission date.

Due to the COVID emergency, all forms should be submitted via EDITS or via eFax for manual submitters to:

- NHED New applications: 917-639-0735
- NHED Conversions and Undercare only: 917-639-0736
- NHED Deferrals: 917-639-0679
- NHED Expedited Discharge NH only: 917-639-0687

For additional information regarding easements during the COVID 19 emergency, please see the Medicaid Alert – New York State Medicaid Modifications COVID-19 Emergency dated March 30, 2020.

The MAP forms listed below have been revised (see copies attached to this Alert), effective on XXX only forms with revision date XXXX will be accepted. Important changes to the forms are discussed below:

<table>
<thead>
<tr>
<th>FORM NUMBER</th>
<th>FORM NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAP-259d</td>
<td>Discharge Alert – Non-Chronic Budget – Fee-For-Service and Managed Long-Term Care Only</td>
</tr>
<tr>
<td>MAP-259e</td>
<td>Change or Cancellation of Discharge Plan</td>
</tr>
<tr>
<td>MAP-259f</td>
<td>Discharge Notice</td>
</tr>
</tbody>
</table>

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
Medical Assistance Program • Office of Eligibility Information Services • 785 Atlantic Avenue, Brooklyn, NY 11238
Steven Banks, Commissioner ● Karen Lane Executive Deputy Commissioner ● Maria Ortiz-Quezada, Director of EIS
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>MAP-259g</td>
<td>6/25/2020</td>
</tr>
<tr>
<td>11</td>
<td>MAP-259t</td>
<td>5/29/2020</td>
</tr>
<tr>
<td>12-13</td>
<td>MAP-2159</td>
<td>12/29/2022</td>
</tr>
<tr>
<td>14</td>
<td>MAP-2159i</td>
<td>6/11/2020</td>
</tr>
<tr>
<td>15</td>
<td>MAP-2159w</td>
<td>5/29/2020</td>
</tr>
<tr>
<td>16</td>
<td>MAP-648p</td>
<td>5/5/2022</td>
</tr>
</tbody>
</table>

The revised forms have been posted on MARC in the Nursing Home and Managed Long-Term Care plan sections. They can be accessed at [http://www1.nyc.gov/marc](http://www1.nyc.gov/marc). Effective immediately, facilities and managed care plans are to begin using the revised forms.

*It is important to note that the MAP-2159i now requires an RHCF physician’s signature. Older versions of this form without a physician’s signature will no longer be accepted.*

**Also effective immediately, the MAP-648P has been revised to remove the MAP-751P- Consent to Release Information. MAP-751P is obsolete and will not be needed as part of the application/conversion submission process.

Any questions regarding the use of the forms referenced above should be directed to the Nursing Home Eligibility Division Provider Relations Unit at 718-557-1368

**PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF**
This ALERT is to inform Residential HealthCare Facilities (RHCFs), Managed Care Plans and Managed Long Term Care Plans that, as a result of the transition of long-term nursing home benefit into Medicaid Managed Care, the MAP forms listed below have been revised:

<table>
<thead>
<tr>
<th>FORM NUMBER</th>
<th>FORM NAME</th>
<th>Revised</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAP-259d</td>
<td>Discharge Alert – Non-Chronic Budget – Fee-For –Service and Managed Long Term Care Only</td>
<td></td>
<td>5/29/2020</td>
</tr>
<tr>
<td>MAP-259e</td>
<td>Change or Cancellation of Discharge Plan- Fee-for-Service Only</td>
<td></td>
<td>5/29/2020</td>
</tr>
<tr>
<td>MAP-259f</td>
<td>Discharge Notice</td>
<td>Revised</td>
<td>5-29-2020</td>
</tr>
<tr>
<td>MAP-259g</td>
<td>Respite Stay Medicaid Fee-for-Service</td>
<td></td>
<td>6-25-2020</td>
</tr>
<tr>
<td>MAP-259t</td>
<td>Request to Convert Case</td>
<td>Revised</td>
<td>05-29-2020</td>
</tr>
<tr>
<td>MAP-2159</td>
<td>Notification of Change or Correction to File from Nursing facility</td>
<td></td>
<td>rev. 12/29/2022</td>
</tr>
<tr>
<td>MAP-2159i</td>
<td>Notice of Permanent Placement- Medicaid Managed Care</td>
<td></td>
<td>revised 6/11/2020</td>
</tr>
<tr>
<td>MAP-2159W</td>
<td>Permanent Placement Disenrollment Request</td>
<td></td>
<td>5/29/2020</td>
</tr>
<tr>
<td>MAP-648p</td>
<td>Submission of Request from Residential Healthcare Facilities (RHCF)</td>
<td>Revised</td>
<td>5/5/2022</td>
</tr>
</tbody>
</table>
The revised forms have been posted on MARC in the Nursing Home and Managed Long Term Care plan sections. They can be accessed at http://www1.nyc.gov/marc.

Effective immediately, facilities and managed care plans are to begin using the revised forms. See pages 3 and 4 of this Alert for a chart providing usage instructions for these forms.

**Note:** The final PDF version of the PowerPoint presentation for the transition of long-term nursing home benefit into Medicaid Managed Care has also been posted on MARC. It may be accessed from the Nursing Home, Managed Care and Managed Long Term Care Plan sections of the MARC directory in the Reference guides folder.

Any questions regarding the use of the forms referenced above, or the PDF of PowerPoint presentation, should be directed to the Nursing Home Eligibility Division Provider Relations Unit at 718-557-1368.
Revised Forms for Long Term Nursing Home Benefit in Medicaid Managed Care

<table>
<thead>
<tr>
<th>Form Number</th>
<th>Form Name</th>
<th>Clients</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAP-2159i</td>
<td>Notice of Permanent Placement- Medicaid Managed Care</td>
<td>Managed Care Only</td>
<td>Initial determination by Managed Care Plan of permanent placement for managed care clients (mainstream and MLTC) from Plan and RHCF</td>
</tr>
</tbody>
</table>
| MAP-2159W   | Permanent Placement Disenrollment Request                                | Mainstream Managed Care clients who are permanently placed and excluded from mandatory enrollment  
- Consumers <21 years  
- Permanently placed in ICF  
- Permanently placed in out-of-state facility | To request disenrollment for mainstream managed care clients who are permanently placed – and not subject to NH transition mandatory enrollment |
| MAP-648p    | Submission of Request from Residential Healthcare Facilities (RHCF)      | All                                          | Submission of new applications, conversion requests, coverage upgrade to LTC, end of penalty period. |
| MAP-259d    | Discharge Alert – Non-Chronic Budget – Fee-For-Service and Managed Long Term Care Only | Fee-for-service and MLTC                    | Indication of client intent to return home; non-chronic budget.      |
| MAP-259e    | Change or Cancellation of Discharge Plan- Fee-for-Service Only           | Fee-for-Service                             | Report of change in client discharge;  
- New discharge date  
- Cancellation of discharge plan |
| MAP-259f    | Discharge Notice                                                          | All                                          | Report of discharge of Nursing Home client to community or other facility. |
| MAP-259g    | Respite Stay Medicaid Fee-for-Service                                     | Fee-For-Service                             | Notification of period of Respite Stay.                               |
## Revised Forms for Long Term Nursing Home Benefit in Medicaid Managed Care

<table>
<thead>
<tr>
<th>MAP-259t</th>
<th>Request to Convert Case</th>
<th>All</th>
<th>Request to convert case to coverage of long term nursing home care; notice of discharge/death; notice of TPHI; notice of managed care enrollment (mainstream and MLTC).</th>
</tr>
</thead>
</table>
| MAP-2159 | Notification of Change or Correction to File from Nursing Facility | All | Notification of status changes for Nursing Home clients  
  - Facility Transfer  
  - Bed hold  
  - Change in Financial Information  
  - Demographic Change  
  - Change in health insurance information  
  - Bed type change (mainstream managed care clients only) |
TO:
Medical Assistance Program
NHED - Expedited Discharge Unit
P.O. Box 24210
Brooklyn, NY 11202-9810

FROM:

Submit this form with the application or conversion packet.

LAST NAME
FIRST NAME
CIN

Upon completion of a rehabilitation program the above-named resident is planning to return to community living. Diagnosis __________________________________________________________

Anticipated discharge date: ____________________________________________

PLANNED LIVING ARRANGEMENTS:

☐ Own Home/Apartment
☐ Relative’s Home
☐ ALPS
☐ Congregate Care
☐ Adult Home

ATTESTATION
I, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and is supported by medical records on file at the facility. I may be contacted for further clarification.

PHYSICIAN’S NAME (Print)  SPECIALITY  PHYSICIAN’S SIGNATURE

DATE FORM SIGNED  LICENSE NO.  TELEPHONE NO.

DO NOT FAX THIS FORM. The original must be mailed. EDITS Nursing Home submitters must retain the original in the consumer’s record.
CHANGE OR CANCELLATION IN DISCHARGE PLAN

TO:  
Medical Assistance Program  
NHED - Expedited Discharge Unit  
P.O. Box 24210  
Brooklyn, NY 11202-9810

FROM:  
NAME OF FACILITY

ADDRESS

PROVIDER NUMBER

CONTACT PERSON

TELEPHONE

EMAIL ADDRESS

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>CIN</th>
</tr>
</thead>
</table>

Original anticipated discharge date ____________________________

Please note the following changes in the discharge plan of the above-named resident.

**CHANGE IN MEDICAL CONDITION**

- [ ] Discharge delayed, new anticipated date of discharge is ____________________________
- [ ] Discharge plan canceled effective_________________ Consumer is in long-term placement

Reason(s) for change ________________________________________________________

__________________________________________________________________________

**PHYSICIAN’S CERTIFICATION**

I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and is supported by medical records on file at the facility. I may be contacted for further clarification.

<table>
<thead>
<tr>
<th>PHYSICIAN’S NAME (Print)</th>
<th>SPECIALITY</th>
<th>PHYSICIAN’S SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE FORM SIGNED</th>
<th>LICENSE NO.</th>
<th>TELEPHONE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DO NOT FAX THIS FORM. The original must be mailed.** EDITS Nursing Home submitters must retain the original in the consumer’s record.

If the consumer is enrolled in managed care, the following must be signed by consumer’s Managed Care Plan.

<table>
<thead>
<tr>
<th>NAME OF PLAN</th>
<th>PLAN ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LAST NAME (Print)</th>
<th>FIRST NAME (Print)</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>TELEPHONE</th>
<th>EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This form MUST be submitted at the actual time of discharge. Providers submitting manually must fax this form to (917) 639-0687. Providers using EDITS must submit through EDITS.

TO:
Medical Assistance Program
NHED - Expedited Discharge Unit
P.O. Box 24210
Brooklyn, NY 11202-9810

FROM:
NAME OF FACILITY
ADDRESS
PROVIDER NUMBER
CONTACT PERSON
EMAIL ADDRESS

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>CIN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Consumer Expired

Date of Death: ______________________

The above-named resident was discharged on ______________________ to the following: (check box below)

☐ Out of State ☐ Own Home ☐ Relative’s Home ☐ Intermediate Residential Alternative (IRA)
☐ Out of County ☐ ALP ☐ Congregate Care ☐ Hospital ☐ AWOL
☐ Adult Home ☐ Other (specify) ______________________

If the resident was discharged to another Nursing Home, use MAP-2159 form and submit to the Transaction Unit.

Address of above: ______________________ Zip Code: ______

Contact Person for new residence: ______________________ Telephone Number: ______

Dialysis services needed: ☐ Yes ☐ No If “yes”, name of center: ______________________

Is the consumer enrolled in a Medicaid Managed Long-Term Care Plan or will be enrolled upon discharge? ☐ Yes ☐ No

Discharged to Own Home:

☐ Resident was notified of the availability of the Special Income Standard for housing expenses for individuals discharged from a nursing facility and who have enrolled in a Managed Long-Term Care (MLTC) Program.

☐ Check box if MAP-3057 was given or sent to the resident/consumer upon discharge.
The above named consumer was admitted to this Residential Health Care Facility for a Respite Stay from _____________ to _____________ for a period of ________________ days.

Facility Representative (Print) __________________________ Telephone Number __________________________

Facility Representative (Sign) __________________________ Date __________________________
REQUEST TO CONVERT CASE

TO:  
Medical Assistance Program  
Nursing Home Eligibility Division (NHED)  
P. O. Box 24210  
Brooklyn, NY 11202-9810

FROM:  
Name of Facility

Address:

Provider No:

Medicaid Coverage Date:

CASE DESCRIPTION:  
CONVERT:

☐ Non-Spousal  
☐ Former resident discharged within past 12 months

☐ Spousal

RESIDENT INFORMATION

Last Name _____________________________ First Name: _____________________________
Date of Birth ___________________________ Client Identification _____________________________
Number (CIN): ___________________________

If requesting non-chronic care budgeting, attach MAP-259d, Discharge Alert

If expired, date: _____ / _____ / _____

If discharged, date: _____ / _____ / _____  Discharged to:

☐ Facility Name _____________________________

☐ Community _____________________________

MEDICAID MANAGED CARE: Please attach the MAP-2159i, if the consumer is a managed care enrollee who was approved for long-term placement. The request for long-term placement is still valid if the consumer was discharged and re-admitted within 12 months of the long-term placement request.

☐ Managed Long Term Care  
☐ Mainstream Managed Care (do not submit for rehabilitative stay)

HEALTH INFORMATION: (Submit a copy of Third Party Health Insurance)

☐ The individual is in receipt of Medicare coverage for nursing facility services and/or has other health insurance coverage at the time of admission.

☐ Third party health insurance coverage was terminated on (date)

Policy Name ___________  Policy Number ___________  Policy Effective Date _____ / _____ / _____

Submit a copy of insurance cover page

RHCF REPRESENTATIVE (PRINT NAME)  
TITLE

TELEPHONE NUMBER  
EMAIL ADDRESS
NOTIFICATION OF CHANGE/CORRECTION/UPDATE

EDITS submitters should submit via edits. All other submitters can fax the MAP-2159 to 917-639-0736 or mail to the address listed on the form.

Date: ________________________

To:
Human Resources Administration
Medical Assistance Program
Nursing Home Eligibility Division
P.O. Box 24210
Brooklyn, NY 11202-9810

Consumer is admitted to the following:

Name of Facility
Facility Address
Facility Provider ID
Consumer’s Name (Last, First)
CIN

CHECK ONE BOX ➔

☐ NOTIFICATION OF CHANGE
☐ CORRECTION TO FILE FROM NURSING FACILITY
☐ QUARTERLY SUBMISSION OF PIA/PNA

PLEASE SEND ORIGINAL FORM AND DOCUMENTATION, WHERE APPLICABLE, TO THE MEDICAL ASSISTANCE PROGRAM.
KEEP A COPY FOR YOUR RECORD.

1 □ STATUS CHANGE (Check one only)

☐ (a) Admitted from another NF only (directly or via hospital)

☐ (b) Admitted to hospital eligible for bedhold

□ Yes □ No

NAME OF HOSPITAL (If applicable)

☐ (c) Therapeutic Leave eligible for bedhold

□ Yes □ No

NAME/ADDRESS

DATE

CURRENT LEVEL OF CARE

☐ SNF ☐ ICF

☐ (d) BEDHOLD TERMINATION DATE

FROM: PROVIDER ID NUMBER

☐ (e) DATE RETURNED

TO: PROVIDER ID NUMBER

☐ (f) DECEASED/DATE OF DEATH

2 □ CHANGE IN FINANCIAL INFORMATION

<table>
<thead>
<tr>
<th>TYPE OF CHANGE</th>
<th>CURRENT MONTHLY AMOUNT BUDGETED (IF KNOWN)</th>
<th>NEW MONTHLY AMOUNT TO BE BUDGETED</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Gross</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Pension - Veterans</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Pension - Other</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Health Insurance Premium</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>
DEMOGRAPHIC CHANGE

NAME
DOB
SEX □ MALE □ FEMALE

CHANGE IN HEALTH INSURANCE INFORMATION

☐ The individual is in receipt of Medicare coverage for nursing facility services and/or has other health insurance coverage at the time of admission.

☐ The consumer is in receipt of other Health Insurance at the time of admission. If so, please provide documentation.

☐ Medicare or other third party health insurance coverage was terminated on ______________________ (date).

MEDICARE NO. □ Part A □ Part B START DATE

RESTRICTION EXEMPTION CODES The Managed Care Plan must authorize a change in status by signing Section 6 of this form.

R/E Code Description: Date:
☐ N1 Regular SNF Rate – MC Enrollee
☐ N2 SNF AIDS – MC Enrollee
☐ N3 NF Neuro-Behavioral – MC Enrollee
☐ N4 SNF TBI – MC Enrollee
☐ N5 SNF Ventilator Dependent – MC Enrollee
☐ N6 Cannot be Requested

INDIVIDUAL COMPLETING FORM: The following must be completed in order for NHED to consider the reported information on this form.

A. Managed Care Plan Person Authorizing Bed-Type and Long Term Placement:

Name of Plan
Plan Provider ID or ePACES code
Last Name (Print) First Name (Print) Department
Signature Contact Telephone Number Email Address

B. If submitted by a Residential Healthcare Facility (RHCF):

RHCF Name Provider ID
Last Name (Print) First Name (Print) Department
Signature Contact Telephone Number Email Address

QUARTERLY SUBMISSION OF PIA/PNA (Must be accompanied with banking statements/documentation)

Dates: From: To:

Request for Last Quarter Total Receipts Total Expenditures Current Balance

$ $ $ $
NOTICE OF LONG-TERM PLACEMENT MEDICAID MANAGED CARE

DATE

NAME OF FACILITY

ADDRESS

CONTACT PERSON

TELEPHONE

EMAIL ADDRESS

PROVIDER NUMBER

CONSUMER LAST NAME

CONSUMER FIRST NAME

CIN

This is to certify that the above-named consumer is a resident of the above-named facility and is now in long-term placement status. The long-term placement is effective ___ / ___ / _______. The consumer’s Managed Care Plan listed below has authorized the placement bed type. The consumer must receive a copy of this form. A copy of this form was sent to the consumer on ___ / ___ / _______.

The following must be signed by the Residential Healthcare Facility (RHCF):

PHYSICIANS LAST NAME (Print)  PHYSICIANS FIRST NAME (Print)

PHYSICIANS SIGNATURE

TELEPHONE

EMAIL

The placement/bed type for the consumer is checked below:

<table>
<thead>
<tr>
<th>R/E Code</th>
<th>Description</th>
<th>R/E Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N1</td>
<td>Regular SNF Rate – MC Enrollee</td>
<td>□ N4</td>
<td>SNF TBI – MC Enrollee</td>
</tr>
<tr>
<td>□ N2</td>
<td>SNF AIDS – MC Enrollee</td>
<td>□ N5</td>
<td>SNF Ventilator Dependent – MC Enrollee</td>
</tr>
<tr>
<td>□ N3</td>
<td>NF Neuro-Behavioral – MC Enrollee</td>
<td>□ N6</td>
<td>MLTC Enrollee Placed in SNF</td>
</tr>
</tbody>
</table>

The following must be signed by the consumer’s managed care plan in order (other than HARP) for NHED to process the reported information on this form.

A. Managed Care Plan Person Authorizing Bed Type and Long – Term Placement:

Name of Plan

Plan ID

Last Name (Print)  First Name (Print)  Department

Signature  Contact Telephone Number

Third Party Health Insurance Information:

□ The individual is in receipt of Medicare for nursing facility services and/or has other third party health insurance coverage at the time of admission.

□ Medicare or other third party health insurance benefits were exhausted on _______________________ (date).
This is to certify that the above named consumer is a long-term placed resident of this facility and will not return to the community. This evaluation was determined by a qualified assessor.

The consumer was admitted to our facility on \_\_/\_\_/\_\_ and was determined to be long-term placed effective \_\_/\_\_/\_\_. I am requesting that the above referenced consumer is disenrolled from their Managed Care Plan for the following reason(s):

<table>
<thead>
<tr>
<th>Categories</th>
<th>Consumer submitted in this category? (Check if ‘Yes’)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer is 20 years of age and younger</td>
<td>☐</td>
</tr>
<tr>
<td>Consumer is residing in Intermediate Care Facility (ICF)</td>
<td>☐</td>
</tr>
<tr>
<td>Consumer is residing in an out-of-state facility</td>
<td>☐</td>
</tr>
<tr>
<td>Other (specify):</td>
<td>☐</td>
</tr>
</tbody>
</table>

By signing this document, I am attesting that I am the treating physician for the referenced consumer and that the aforementioned is correct. I have reviewed the Patient Review Instrument (PRI) and agree with the qualified assessor.
# Submission of Request from Residential Health Care Facilities (RHCF)

**FROM:**
FACILITY NAME
ADDRESS
CITY  STATE  ZIP
PROVIDER ID

**TO:**
Human Resources Administration
Medical Assistance Program
Nursing Home Eligibility Division
P.O. Box 24210
Brooklyn, NY 11202-9810

Date: ______________________________

Manual Submitters: Send two copies of this form in order to receive a return receipt as an acknowledgement of request. EDITS submitters will receive an electronic notification.

<table>
<thead>
<tr>
<th>NAME OF APPLICANT (LAST, FIRST)</th>
<th>CIN</th>
<th>REQUESTED MEDICAID COVERAGE START DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DOES RESIDENT HAVE A SPOUSE LIVING IN THE COMMUNITY?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Date of Hospital Admission: ___________________________ or ☐ Direct From Community to Nursing Home

Your submission will not be accepted unless all listed items in the first column are attached.

- **NEW APPLICATION:** Applicants who **did not have** active Medicaid coverage at the time of Nursing Facility admission.
  - 29 Days of Short Term Rehabilitation
  - DOH-4220, Application For Medical Assistance and DOH-4495a or 5178a, Supplement A
  - PRI (Pages 1-4)

- **CONVERSION:** Applicants who **have** Community Medicaid coverage at the time of Nursing Facility admission. **This includes PA and SSI Cases**
  - 29 Days of Short Term Rehabilitation
  - DOH 4495a or 5178a, Supplement A
  - PRI (Pages 1-4)

- **STREAMLINED CONVERSION:** For former resident discharged and active within past 12 months.
  - MAP-259t, Request to Convert Case

- **UPGRADE REQUEST TO LTC COVERAGE/ALL COVERED CARE AND SERVICES:** For recipients accepted for Community coverage with or without Community-based Long Term Care.
  - All missing resource documentation listed on MAP-3081, Notice of Acceptance of Your Medical Assistance Application (RVI) and/or MAP-3079 and/or MAP-3079b or MAP-3024e, Request for Information.
  - Transfer Penalty has expired.

Where applicable, submit document(s) from list below
- MAP-259D, Discharge Alert
- MAP-259h, Intent to Return Home
- OOS N/S SNF Prior Approval - OHIP Approval Included
- MAP-2159i, Notice of Long-Term Placement Medicaid Managed Care
- NYS Partnership Plan LTC 90 day Letter

For applicants under age 65 and not blind with income over 138% of the Federal Poverty Level (FPL)
- *LDSS-486T, Medical Report for Determination Disability
- *LDSS-1151, Disability Interview

<table>
<thead>
<tr>
<th>RHCF REPRESENTATIVE (Print Name)</th>
<th>SIGNATURE</th>
<th>TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMAIL ADDRESS</td>
<td>TELEPHONE NUMBER</td>
<td></td>
</tr>
</tbody>
</table>