NOTICE OF PERMANENT PLACEMENT
MEDICAID MANAGED CARE

NYC Human Resources Administration
Department of Social Services

MAP-2159i 04/03/2015

DATE	
NAME OF FACILITY	
ADDRESS	
NAME OF MEDICAID MANAGED CARE PLAN	PLAN PROVIDER ID
NAME OF CONSUMER	CIN

SEND TO:

Medical Assistance Program
Nursing Home Eligibility Division
P.O. Box 24210
Brooklyn, New York 11202-9810

This is to certify that the above-named consumer is a resident of the above-named facility and is now in permanent placement status. The permanent placement is effective _____/_____/_____

The consumer's Managed Care Plan listed above has authorized the placement and/or bed type. The signed Plan Authorization is attached.

Plan Authorization must be attached or this action will not be processed.

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

	R/E Code	Description
☐	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	MLTC Enrollee Placed in SNF

The following must be signed by the consumer's managed care plan and the residential health care facility providing care in order for NHED to process the reported information on this form.

A. Managed Care Plan:

Name of Plan	Plan ID	
Submitter Last Name (Print)	Submitter First Name (Print)	Department
Signature	Contact Telephone Number	

B. Residential Healthcare Facility (RHCF):

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