Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

NOTE: Forms attached by NYLAG as updated by HRA through 3/24/2023

June 22, 2020

Nursing Homes Forms Update

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:

dates of forms below added by NYLAG 3-24-23

PAGE	FORM NUMBER		FORM NAME
7	MAP-259d	(5-29-20)	Discharge Alert – Non-Chronic Budget – Fee-For-Service and Managed Long-Term Care Only
8	MAP-259e	(5-29-20)	Change or Cancellation of Discharge Plan
9	MAP-259f	(5-29-20)	Discharge Notice

10	MAP-259g 6/25/2020	Respite Stay Medicaid Fee-for-Service
11	MAP-259t 5/29/2020	Request to Convert Case
12-13	MAP-2159 12/29/2022	Notification of Change or Correction to File from Nursing Facility
14	MAP-2159i 6/11/2020	Notice of Long-Term Placement - Medicaid Managed Care*
15	MAP-2159w 5/29/2020	Long-Term Placement Disenrollment Request
16	MAP-648p 5/5/2022	Submission of Request from Residential Healthcare Facilities (RHCF)**

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.

***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 APPROPIATE STAFF

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*

Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

form dates updated by NYLAG as of 3/24/23 - copies attached

OCTOBER 28, 2015

Nursing Home Transition into Managed Care: Forms and PDF Training Material

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:

PAGE	FORM NUMBER	FORM NAME
7	MAP-259d	Discharge Alert – Non-Chronic Budget – Fee-For –Service and Managed Long Term Care Only 5/29/2020
8	MAP-259e	Change or Cancellation of Discharge Plan- Fee-for-Service Only 5/29/2020
9	MAP-259f	Discharge Notice Revised 5-29-2020
10	MAP-259g	Respite Stay Medicaid Fee-for-Service 6-25-2020
11	MAP-259t	Request to Convert Case Revised 05-29-2020
12-13	MAP-2159	Notification of Change or Correction to File from Nursing facility rev. 12/29/2022
14	MAP-2159i	Notice of Permanent Placement- Medicaid Managed Care revised 6/11/2020
15	MAP-2159W	Permanent Placement Disenrollment Request 5/29/2020
16	MAP-648p	Submission of Request from Residential Healthcare Facilities (RHCF) Revised 5/5/2022

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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.

PLEASE SHARE THIS ALERT WITH ALL APPROPIATE STAFF

Form Number	Form Name	Clients	Use
MAP-2159i	Notice of Permanent Placement- Medicaid Managed Care	Managed Care Only	Initial determination by Managed Care Plan of permanent placement for managed care clients (mainstream and MLTC) from Plan and RHCF
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.

MAP-259t	Request to Convert Case	All	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).
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)

10/28/2015 3:43 PM

DISCHARGE ALERT
Non-Chronic Budget
Fee-for-Service and Managed Long Term Care Only

Human Resources Administration
Department of Social Services

MAP-259d (E) 05/29/2020
(Replaces MAP-1122)

Date _____

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	

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
- ☐ ALPS
- ☐ Adult Home
- ☐ Relative's Home
- ☐ Congregate Care

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

Human Resources Administration
Department of Social Services

MAP-259e (OHIP-3560) 05/29/2020
(Replaces MAP-1123)

Date: _____

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

LAST NAME	FIRST NAME	CIN

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.

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.

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

NAME OF PLAN		PLAN ID
LAST NAME (Print)	FIRST NAME (Print)	TITLE
SIGNATURE	TELEPHONE	EMAIL

DISCHARGE NOTICE

Human Resources Administration
Department of Social Services

MAP-259f (OHIP3563) 05/29/2020
(Replaces MAP-1124)

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.

Date: _____

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	

LAST NAME	FIRST NAME	CIN

☐ Consumer Expired Date of Death: _____

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

☐ Out of State ☐ Own Home ☐ Relative's Home ☐ Intermediate Residential Alternative (IRA) ☐ Shelter

☐ 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.

RESPITE STAY
MEDICAID FEE-FOR-SERVICE

Human Resources Administration
Department of Social Services

MAP-259g 06/25/2020

DATE: _____

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	

LAST NAME	FIRST NAME	CIN

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

Human Resources Administration
Department of Social Services

MAP-259t 05/29/2020

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:

☐ Non-Spousal

☐ Spousal

CONVERT:

☐ Former resident discharged within past 12 months

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

NYC Human Resources Administration
Department of Social Services

MAP-2159 12/29/2022

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.

❶ ❑ **STATUS CHANGE (Check one only)**

❑ **(a)** Admitted from another NF only (directly or via hospital)		❑ **(b)** Admitted to hospital eligible for bedhold ❑ Yes ❑ No	DATE
		NAME OF HOSPITAL (If applicable)	
		❑ **(c)** Therapeutic Leave eligible for bedhold ❑ Yes ❑ No	DATE
		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	

❷ ❑ **CHANGE IN FINANCIAL INFORMATION**

TYPE OF CHANGE	CURRENT MONTHLY AMOUNT BUDGETED (IF KNOWN)	NEW MONTHLY AMOUNT TO BE BUDGETED	EFFECTIVE DATE
Social Security Gross	$	$	
Pension - Veterans	$	$	
Pension - Other	$	$	
Health Insurance Premium	$	$	
Other	$	$	
Other	$	$	

❸ ❑ **DEMOGRAPHIC CHANGE**

NAME	DOB	SEX ❑ MALE ❑ FEMALE

❹ ❑ **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 admissions. 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

❺ ❑ **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**	

❻ ❑ **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

❼ **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

NYC Human Resources Administration Department of Social Services

MAP-2159i (OHIP-3561) 06/11/2020

DATE	
NAME OF FACILITY	
ADDRESS	
CONTACT PERSON	
TELEPHONE	EMAIL ADDRESS
PROVIDER NUMBER	

SEND TO:

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

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:

R/E Code	Description	R/E Code	Description
☐ N1	Regular SNF Rate – MC Enrollee	☐ N4	SNF TBI – MC Enrollee
☐ N2	SNF AIDS – MC Enrollee	☐ N5	SNF Ventilator Dependent – MC Enrollee
☐ N3	NF Neuro-Behavioral – MC Enrollee	☐ N6	MLTC Enrollee Placed in SNF

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).

LONG-TERM PLACEMENT DISENROLLMENT REQUEST

NYC Human Resources Administration
Department of Social Services

MAP-2159w 05/29/2020

DATE	
NAME OF RHCF	
ADDRESS	
NAME OF MEDICAID MANAGED CARE PLAN	PLAN PROVIDER ID
NAME OF CONSUMER	CIN
CONTACT PERSON (Submitting this form)	PHONE
EMAIL ADDRESS	

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 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):

Categories	Consumer submitted in this category? (Check if 'Yes')
Consumer is 20 years of age and younger	❒
Consumer is residing in Intermediate Care Facility (ICF)	❒
Consumer is residing in an out-of-state facility	❒
Other (specify):	❒

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.

NAME OF TREATING PHYSICIAN (Print)	PHYSICIAN'S LICENSE NUMBER
SIGNATURE OF TREATING PHYSICIAN	DATE

SUBMISSION OF REQUEST FROM RESIDENTIAL HEALTH CARE FACILITIES (RHCF)

NYC Human Resources Administration
Department of Social Services

MAP-648p 05/05/2022

Date: _____

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

fold_ _fold

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.

NAME OF APPLICANT (LAST, FIRST)	CIN	DATE OF RHCF ADMISSION
REQUESTED MEDICAID COVERAGE START DATE	DOES RESIDENT HAVE A SPOUSE LIVING IN THE COMMUNITY? ❒ Yes ❒ No	

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)

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

○ **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.

RHCF REPRESENTATIVE (Print Name)	SIGNATURE	TITLE
EMAIL ADDRESS	TELEPHONE NUMBER	