

Managed Long Term Care Exclusion Form



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New York Medicaid Choice

INSTRUCTIONS

Please fill in Section A and sign it. Add a check mark to select the Sections that apply to you and follow the instructions on how to apply for each Exclusion type.

Section A You Must Fill in and Sign This Section

Name: _____ Benefit ID #: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

Signature: _____

Date: _____

Home Telephone #

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(Area Code)

Cell Phone #

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(Area Code)

I understand the following:

- I am asking for an exclusion from the New York Medicaid Choice program. I cannot join a Managed Long Term Care Plan.
- I may need to give information about my medical condition. I give my Provider permission to give New York Medicaid Choice all needed medical information only if it is relevant to my request for the exclusion. This may include mental health, HIV, alcohol or substance abuse, or disability information, if it is needed for this exclusion request.
- I know that if I am now in a plan and I am approved for an exclusion, I will be disenrolled from that plan.

The following individuals are excluded from joining a Managed Long Term Care Plan

Section B People who are receiving family care home services by an agency licensed by the Office of Mental Health.

Fill in Section A and sign it. Return the form in the envelope along with a letter on official letterhead from the family care home agency stating when the applicant started with the program.

Continued on back

If you have trouble reading, understanding or completing this form, please call us.

New York Medicaid Choice

1-888-401-MLTC or 1-888-401-6582

TTY: 1-888-329-1541

Monday – Friday, 8:30 am – 8:00 pm

Saturday, 10:00 am – 6:00 pm

Section C People who are receiving hospice care.

Fill in Section **A** and sign it. Return the form in the envelope along with a letter from the hospice care facility or hospice provider. The letter should include the consumer's diagnosis. If the letter is from a facility, the letter should also have expected length of stay. The letter must be signed by a facility's medical physician and include the provider's license number.

Section D People who have a developmental disability.

Fill in Section **A** and sign it. Take this form to a Physician or a Qualified Mental Retardation Professional and ask them to fill out the Provider Information Box that appears at the end of this page. Return the completed form in the envelope you received with this packet.

Section E Residents of Intermediate Care Facility for the Developmentally Disabled.

Fill in Section **A** and sign it. Return the form in the envelope along with a letter on official letterhead from a developmental disabled professional or agency providing services. The letter must state the applicant's diagnosis and attest that he/she is currently a resident of the facility.

Section F Resident of Alcohol and Substance Abuse Long Term Care Residential Program.

Fill in Section **A** and sign it. Return the form in the envelope along with a letter from the facility on official letterhead. The letter must state date of entry and expected length of stay and be signed by the facility director.

Section G Individuals with complex mental health needs receiving services in their homes and communities through the ICF and HCBS Waivers.

Fill in Section **A** and sign it. Take this form to a Physician or a Qualified Mental Retardation Professional and ask them to fill out the Provider Information Box that appears at the end of this page. Return the completed form in the envelope you received with this packet.

Section H Adults in Foster Care Homes.

Fill in Section **A** and sign it. Return the form in the envelope along with a letter from the foster care agency or foster care worker at the local Social Services office on official letterhead. The letter must state that the individual is receiving foster care services.

PROVIDER INFORMATION BOX

Note for Medical Provider: The applicant must be receiving extensive/complex care in the home at least 120 days as a result of developmental or physical disability or traumatic brain injury. The Medical Provider Box listed below must be filled in by a Physician or a Qualified Mental Retardation Professional.

Date: _____ Provider/Physician*: _____

(mm/dd/yy)

Specialty: _____ License #: _____

MMIS Provider ID #: _____ Diagnosis: _____

Length of treatment: (Start date) _____ (End Date) _____

Name of (Clinic/Facility): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: () _____ Fax: () _____

* Must be signed by an Attending Physician, or by a Qualified Mental Retardation Professional for Sections D and G.
Information provided in this form is subject to verification by the New York State Department of Health, Human Resources Administration, the Local Department of Social Services, or New York Medicaid Choice.