MLTC/NHED COVER SHEET

HCSP-3047b 01/26/2015

Home Care Services Program
Centralized Medicaid Eligibility Unit
785 Atlantic Avenue, 7th Floor
Brooklyn, New York 11238

DATE: ______________________

PLAN NAME: ______________________

CONTACT NAME: ______________________

CONSUMER NAME: ______________________ CIN: ______________________

SOCIAL SECURITY # ____________
(Last four digits only)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

NURSING HOME TRANSACTIONS

You MUST indicate a requested action:

☐ NAMI request (Include resource documentation)

Name of facility: ______________________ Address: ______________________

Provider ID: ______________________ ______________________

Date of Permanent placement: ______________________

☐ Consumer newly permanently placed in a nursing home **or**

☐ Change of nursing home facility (Complete facility information below)

Name of facility: ______________________ Address: ______________________

Provider ID: ______________________ ______________________

Date of permanent placement/move: ______________________

☐ Consumer returning to the community from a nursing home (MAP-259F required)

Date of discharge: ____________ Requested MLTC enrollment date: ______________________

New residence address: ______________________

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☐ Consumer returning to community and remaining enrolled in the plan