SUBMISSION OF REQUEST FROM RESIDENTIAL HEALTH CARE FACILITIES (RHCF)

NYC Human Resources Administration
Department of Social Services

MAP-648p 06/15/2015

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

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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-4495, Supplement A ☐ PRI (Pages 1-4)	**Where applicable, submit document(s) from list below** • MAP-258m, Medicare Buy-In Eligibility Review • MAP-259D, Discharge Alert • MAP-259h, Intent to Return Home • MAP-751P, Consent to Release Information • OOS N/S SNF Prior Approval - OHIP Approval Included • MAP-2159i accompanied with the plan's authorization
○ **CONVERSION:** Applicants who **had** Community Medicaid coverage at the time of Nursing Facility admission. ○ 29 Days of Short Term Rehabilitation ☐ DOH 4495A, Supplement A ☐ PRI (Pages 1-4)	**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 requests to convert case that is active PA, SSI case, or 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, Request for Information.

☐ Transfer Penalty has expired.

RHCF REPRESENTATIVE (Print Name)	SIGNATURE	TITLE	TELEPHONE NUMBER