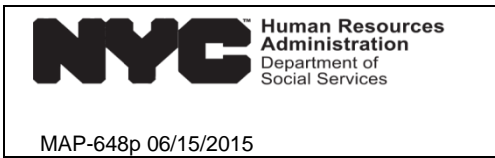


**SUBMISSION OF REQUEST FROM RESIDENTIAL HEALTH CARE FACILITIES (RHCF)**



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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Hospital Admission: _____ or <input type="checkbox"/> Direct From Community to Nursing Home		

**Your submission will not be accepted unless all listed items in the first column are attached.**

<input type="radio"/> <b>NEW APPLICATION:</b> Applicants who <b>did not have</b> active Medicaid coverage at the time of Nursing Facility admission. <input type="radio"/> 29 Days of Short Term Rehabilitation <input type="checkbox"/> DOH-4220, Application For Medical Assistance <b>and</b> DOH-4495, Supplement A <input type="checkbox"/> PRI (Pages 1-4)	<p><b>Where applicable, submit document(s) from list below</b></p> <ul style="list-style-type: none"> <li>• MAP-258m, Medicare Buy-In Eligibility Review</li> <li>• MAP-259D, Discharge Alert</li> <li>• MAP-259h, Intent to Return Home</li> <li>• MAP-751P, Consent to Release Information</li> <li>• OOS N/S SNF Prior Approval - OHIP Approval Included</li> <li>• MAP-2159i accompanied with the plan's authorization</li> </ul> <p><b>For applicants under age 65 and not blind with income over 138% of the Federal Poverty Level (FPL)</b></p> <ul style="list-style-type: none"> <li>• *LDSS-486T, Medical Report For Determination Disability</li> <li>• *LDSS-1151, Disability Interview</li> </ul>
<input type="radio"/> <b>STREAMLINED CONVERSION:</b> For requests to convert case that is active PA, SSI case, or former resident discharged and active within past 12 months. <input type="checkbox"/> MAP-259t, Request to Convert Case	
<input type="radio"/> <b>UPGRADE REQUEST TO LTC COVERAGE/ALL COVERED CARE AND SERVICES:</b> For recipients accepted for Community coverage <b>with or without</b> Community-based Long Term Care. <input type="checkbox"/> 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. <input type="checkbox"/> Transfer Penalty has expired.	

RHCF REPRESENTATIVE (Print Name)	SIGNATURE	TITLE	TELEPHONE NUMBER