SUBMISSION OF REQUEST FROM RESIDENTIAL HEALTH CARE FACILITIES (RHCF)

FROM:

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<th>FACILITY NAME</th>
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TO:

Human Resources Administration
Medical Assistance Program
Nursing Home Eligibility Division
P.O. Box 24210
Brooklyn, NY 11202-9810

Date: _______________________

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)

○ 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)

○ 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.

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

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

RHCF REPRESENTATIVE (Print Name) | SIGNATURE | TITLE | TELEPHONE NUMBER
---------------------------------|-----------|-------|----------------