CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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Janie Miller
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Elizabeth A. Johnson
Commissioner

April 10, 2009

TO: Nursing Facility (12) Provider Letter #A-242
ICF/MR (11) Provider Letter #A-348

RE: MAP-350 NF Form

Dear Kentucky Medicaid NF Provider:

Effective May 1, 2009 please begin using the enclosed MAP-350 NF form. This form has deleted the estate recovery section at the top of the old MAP-350 form. This particular information is explained initially by the local DCBS office upon an individual's application for Medicaid.

The MAP-350 NF is a mandated requirement that all Medicaid members, eligible Medicaid recipients, and/or others, who have been determined by the PRO to meet Nursing Facility Level of Care, are given the choice of receiving services either in an institution or in their home and/or community.

It is the Department's intent that the purpose of this particular form is for individuals to have a meaningful choice between institutional long-term services and home and community-based services.

If you have any questions, please contact Judy Montfort, RN at 502-564-5707.

Sincerely,

Elizabeth A. Johnson
Commissioner

EAJ/jm/vlp00733

Enclosure(s)

DIVISION OF HEALTHCARE FACILITIES MANAGEMENT

MAP – 350 NF INSTRUCTIONS

Purpose of MAP – 350 NF

Center for Medicare and Medicaid Services (CMS) requires that all individuals seeking admission to a nursing facility, ICF/MR/DD facility or a Home and Community Based (HCB) waiver program be given the choice of receiving services in an institution or through Home and Community Based Services.

The MAP – 350 NF is to document that each Medicaid recipient has been given the choice of receiving care in an institution or in a Home and Community Based (HCB) waiver program.

The MAP – 350 NF is required to be completed for each Medicaid recipient prior to admission to a nursing facility or an ICF/MR/DD facility, and annually thereafter.

The original copies of the MAP – 350 NF shall be maintained in the medical record. A copy is to be provided to the recipient/legal representative.

Instructions for Completing the MAP – 350 NF Certification Form

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I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER.

PLEASE NOTE: COMPLETE (A-D) ONLY THE ONE/ONES THAT ARE APPROPRIATE FOR THE RECIPIENT.

A. The HCBS waiver program is for the aged and disabled individual that requires nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for the HCBS program as an alternative to NF placement ***is requested*** _____***;***
is not requested _____***. Sign and date the section.***

B. The Supports for Community Living (SCL) waiver program is for individuals with mental retardation/developmental disabilities that require intermediate care facility for the mentally retarded or developmentally disability (ICF/MR/DD) level of care.

The recipient/legal representative must check their choice. Consideration for the waiver program as an alternative to ICF/MR/DD ***is requested*** _____***;***
is not requested _____***. Sign and date the section, if applicable.***

C. The Model Waiver II program is for individuals that are ventilator dependent and require nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for Model Waiver II program as an alternative to NF placement ***is requested*** _____***;***
is not requested _____***. Sign and date the section, if applicable.***

D. The Acquired Brain Injury waiver program is for individuals aged twenty-one (21) to sixty-five (65) that have sustained a traumatic brain injury and require nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for the ABI Waiver Program as an alternative to NF or NF/ABI placement ***is requested _____; is not requested _____. Sign and date the section, if applicable.***

II. FREEDOM OF CHOICE OF PROVIDER

The recipient/legal representative that elected to receive Home and Community Based waiver services shall be informed that services may be requested from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from the Department for Medicaid Services.
Sign and date the section, if applicable.

III. RESOURCE ASSESSMENT CERTIFICATION

The recipient/legal representative must ***sign and date the section*** to certify that they have been informed of the availability of resource assessments to assist with financial planning provided by the Department for Community Based Services (DCBS).

IV. RECIPIENT INFORMATION

- Enter the Medicaid recipient's name as it appears on the current medical assistance identification (MAID) card:
- Enter the full address where recipient lives:
- Enter the phone number of the recipient:
- Enter the ten digit Medicaid number found on the recipient's MAID card:
- Enter the name (if applicable) of the responsible party/legal representative appointed to make decisions for the recipient. This person would have completed/signed the appropriate sections of this form:
- Enter the full address where the responsible party/legal representative (if applicable) lives:
- Enter the phone number for the responsible party/legal representative (if applicable):
- Enter the signature and title of person assisting with completion of the form:
- Enter the name of the agency/facility that the individual assisting with the completions of the form is employed:
- Enter the full address of the agency/facility:

DIVISION OF HEALTHCARE FACILITIES MANAGEMENT

I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, ACQUIRED BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement ***is requested*** _____***; is not requested*** _____.

_____ _____/_____/_____
Signature ***Date***

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD ***is requested*** _____***; is not requested*** _____.

_____ _____/_____/_____
Signature ***Date***

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement ***is requested*** _____***; is not requested*** _____.

_____ _____/_____/_____
Signature ***Date***

D. ACQUIRED BRAIN INJURY (ABI) WAIVER - This is to certify that I/legal representative have been informed of the ABI Waiver Program. Consideration for the ABI Waiver Program as an alternative to NF or NF/ABI placement ***is requested*** _____***;***
Is not requested _____.

_____ _____/_____/_____
Signature ***Date***

II. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____/_____/_____
Signature ***Date***

III. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____/_____/_____

Signature ***Date***

IV. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

_____

Phone: (_____)_____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: (_____)_____

Signature and Title of Person Assisting with Completion of Form:

_____

Signature ***Title***

Agency/Facility:

_____

Address:

_____

_____