

Current Medicaid Health Plan

**SECTION 1. MEDICAID HEALTH PLAN INFORMATION** 

## Assessment Request Form



NYIA ASSESSMENT REQ FORM-0522

For Medicaid health plan members requiring non-covered community based long term services and supports.

Managed Long Term Care plan individual wants to join										
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SECTION 2.	INDIVIDUAL'S	IDEN.	TIFYIN	G INFO	RMA	TION				
Last Name			<del></del>	First Name				MI DOB (MM/DD/YYYY)		
Medicaid CIN Social:		l Security Number								
I Wieulcalu Cliv SOC		Socials	ciai security Number			Telephone Number  ☐ Landline ☐ Mobile				
Address (No. and Street)		'				City				
State	Zip Code		Email Ad	ldress			1			
AUTHORIZED	REPRESENT	ATIVE	(IF AF	PPLICA	BLE)					
Last Name			Fi	rst Name					MI R	elationship to Individual
Address (No. and Street)				City				State		Zip Code
Telephone Number ☐ Landline ☐ Mobile				<u> </u>	Emai	l Address	I			
behalf of a person for the release of medical information." If you are signing this form on behalf of the individual, you must provide a copy of the authorization/legal document authorizing you to complete this form, unless this information has already been provided to New York Medicaid Choice.  SECTION 3. INDIVIDUAL'S ACKNOWLEDGEMENT / RELEASE OF MEDICAL INFORMATION										
								CAL	IINFC	DRIVIATION
<ul> <li>As explained by New York Independent Assessor (NYIA), I understand:</li> <li>In order to receive Medicaid community based long term services and supports (CBLTSS) not covered by my current plan, I choose to join a Managed Long Term Care (MLTC) plan.</li> <li>The differences between a Medicaid health plan and an MLTC plan.</li> <li>I may not be able to see my current doctors if I change to an MLTC plan.</li> <li>My assessment will determine my eligibility to join an MLTC plan. The NYIA will contact me to schedule the assessment.</li> <li>I give my health care provider permission to share all necessary medical information that is relevant to my request to transfer to an MLTC plan. This may include any disability information needed to confirm needed services that are not available in my Medicaid health plan.</li> </ul>										
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Sign Here	Individual's Signature							Date		
	Authorized Representative's Signature (if applications)				le)			D	ate	
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## **SECTION 4. HEALTH CARE PROVIDER AUTHORIZATION** A physician, nurse practitioner, or physician assistant must fill out this entire section. Health Care Provider's Name hereby confirm that Individual's Name requires the service/services listed below, which makes him/her a candidate to transfer from a Medicaid health plan to an MLTC plan. 4a. Please add check mark ✓ to all that apply. Social and Environmental Supports (wheelchair ramps, grab rails, etc.) ☐ Home Delivered Meals ☐ Social Day Care 4b. Health Care Provider Information/Signature Health Care Provider's Name Specialty \_\_\_\_\_ License # \_\_\_\_\_ Name of Clinic/Facility/Practice \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_ Phone \_\_\_\_\_\_ Fax \_\_\_\_\_ CECTION E MANNACED LONG TERM CARE (MITC) DIANI

SECTION 5. MANAGED LONG TERM CARE (MLTC) PLAN								
The MLTC plan representative who is submitting this form on behalf of the individual must complete this section.								
MLTC Plan Representative's Name								
Title	Date							
Signature	Phone ()							