ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 97 ADM-10

DIVISION: Office of Medicaid Management

TO: Commissioners of Social Services

DATE: May 13, 1997

SUBJECT: Presumptive Medicaid Eligibility for Nursing Facility, Hospice, or Home Health Care Services

SUGGESTED DISTRIBUTION:
- Medicaid Staff
- Public Assistance Staff
- Adult Protective Services Staff
- Fair Hearing Staff
- Legal Staff
- Long Term Care Staff
- Staff Development Coordinators
- Accounting Staff

CONTACT PERSON:
- Elsie Kirk, 1-800-343-8859, ext. 3-5509
- Hospice questions: Bobbi Jennison, ext. 3-4124
- LTHHCP/CHHA questions: Marge Rokjer, ext. 3-3829
- In New York City: 212-383-2512

ATTACHMENTS:
- Presumptive Eligibility Screening Checklist (Attachment I, Available On-line)
- Medical Documentation Transmittal Form (Attachment II, Available On-line)
- Average Regional Medicaid Nursing Facility Per Diem Rates and Upstate and New York City/Metro Alternate Level of Care Rates (Attachment III, Available On-line)
- Presumptive Medicaid Eligibility: Upstate Systems and Notices Flowchart (Attachment IV, Available On-line)
- Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services (Attachment V, Available On-line)
- Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility or In-Patient Hospice Care (Attachment VI, Available On-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref	Misc. Ref.
	88 ADM-14	360-3.7 Part 531	SSL 364-i SSL 368-a		

DSS-296EL (REV. 9/89)

I. PURPOSE

This Administrative Directive (ADM) informs social services districts of required action as a result of the enactment of Chapter 693 of the Laws of 1996, which expands presumptive Medicaid eligibility to certain hospitalized persons who are awaiting discharge and will require nursing facility or hospice care.

II. BACKGROUND

Previously, Social Services Law (SSL) Section 364-i provided for a period of presumptive eligibility for persons in hospitals who are not currently in receipt of Medicaid, and who could receive necessary home health care services if Medicaid was available to help offset the cost of such care. The period of presumptive eligibility begins on the date of discharge from the hospital and continues for up to sixty days or until the standard eligibility determination is completed, whichever is earlier.

SSL Section 364-i was amended to provide presumptive eligibility to persons in hospitals who are not currently eligible for Medicaid, and who could receive necessary hospice or nursing facility care and services if Medicaid was available to help offset the cost of such care.

Department Regulation 18 NYCRR 360-3.7 will be amended to expand presumptive Medicaid eligibility to include coverage of hospice and nursing facility care and services.

The instructions in this ADM replace the instructions set forth in 88 ADM-14 "Presumptive Medicaid Eligibility for Certain Hospitalized Persons," which is cancelled with the release of this ADM.

III. PROGRAM IMPLICATIONS

A. PRESUMPTIVE MEDICAID ELIGIBILITY

1. Eligibility Conditions

An individual will be determined to be presumptively eligible for Medicaid if the following conditions exist:

a. The applicant is receiving care in an acute care hospital at the time of application.

b. A physician certifies that the applicant no longer requires acute hospital care, but requires the type of medical care provided by a Certified Home Health Agency (CHHA), Long Term Home Health Care Program (LTHHCP), nursing facility, or hospice.

c. The applicant or his or her representative states that there is insufficient insurance coverage for this type of care and that the applicant would not otherwise be able to pay for the type of care required.

d. It reasonably appears that 65 percent of the cost of care provided by the CHHA, LTHHCP, nursing facility, or hospice would be less than the cost of continued hospital care computed at the Medicaid rates.

e. The applicant reasonably appears to meet all the criteria, financial and non-financial, for Medicaid. The Screening Checklist (Attachment I) has been developed for social services districts to use to eliminate those cases from the presumptive eligibility process which require in depth reviews to determine eligibility.

2. Presumptive Eligibility Period

The period of presumptive eligibility will begin on the date of discharge from the hospital and continue for sixty days or until the standard eligibility determination is completed, whichever is earlier.

B. COVERED SERVICES

1. Exceptions

During the period of presumptive Medicaid eligibility, all Medicaid covered services will be covered except:

a. hospital-based clinic services;

b. hospital emergency room services;

c. acute hospital inpatient services (except when provided as part of hospice care); and

d. bedhold for an individual determined presumptively eligible for Medicaid coverage of nursing facility services.

2. Coverage Under Standard Medicaid Eligibility

Acute inpatient hospital care is not covered by Medicaid during the presumptive Medicaid eligibility period (except when provided as part of hospice care). However, the social services district will continue to process the application for standard Medicaid eligibility.

C. REIMBURSEMENT FOR SERVICES TO PROVIDERS

Nursing home care, hospice services and services provided by the CHHA or the LTHHCP during a period of presumptive Medicaid eligibility will be reimbursed initially at 65 percent of the Medicaid rate after maximization of any third party health insurance coverage. Services billed by other Medicaid providers (e.g., physicians providing direct patient care not included in the nursing facility per diem, hospice services daily rate, CHHA or LTHHCP plan of care) for services provided during the presumptive period will be reimbursed at the full Medicaid rate. Medicaid will not reimburse providers if the social services district does not accept the individual as presumptively eligible for Medicaid.

1. When the Applicant is Subsequently Determined Eligible for Standard Medicaid

When the applicant is determined to be eligible for standard Medicaid, the nursing facility, hospice, CHHA or LTHHCP provider will be entitled to the remaining 35 percent of the payment. The provider must submit an adjusted claim in order to receive the remaining 35 percent. In addition, any claims for excluded services (e.g., hospital emergency room) received by the applicant during the presumptive eligibility period may be submitted for payment once standard Medicaid eligibility has been established.

2. When the Applicant is Subsequently Determined Ineligible for Standard Medicaid

When the applicant is determined to be ineligible for standard Medicaid, the nursing facility, hospice, CHHA, or LTHHCP provider will not be paid the remaining 35 percent for care and services provided during the presumptive eligibility period. Also, Medicaid will not cover any care or services rendered after the effective date of the notice of ineligibility for standard Medicaid, or after sixty days of presumptive Medicaid eligibility, whichever occurs first. However, the provider may seek reimbursement of the remaining 35 percent from the applicant. In addition, the social services district may seek recoupment from the applicant for Medicaid expenditures during the presumptive eligibility period.

D. HOSPITAL PROCEDURES

The hospital must assist the client in completing the DSS-2921 "Application for Public Assistance, Medical Assistance, Food Stamps, Services." To enable the social services district to determine presumptive Medicaid eligibility, the hospital should forward the following application package:

1. The completed DSS-2921;

2. The completed Screening Checklist (Attachment I);

3. A statement completed by the attending physician that the patient no longer requires care in an acute care hospital, but does require the services available through a CHHA, LTHHCP, nursing facility, or hospice; and

4. A transmittal form such as Attachment II which documents the type of care required in detail sufficient to enable the social services district to determine cost effectiveness for CHHA services and evaluate the appropriateness of care. In addition, the hospital must provide the appropriate documentation which fulfills the current programmatic requirements for a Medicaid applicant to receive services from the LTHHCP, CHHA, nursing facility, or hospice provider.

Since the period of presumptive Medicaid eligibility will begin upon hospital discharge, early identification of potential candidates for presumptive Medicaid eligibility is important. Good communication between the hospital discharge planner, the social services district agent certifying the individual's need for care, when appropriate, and the social services district's eligibility staff is necessary to minimize the number of cases found ineligible for standard Medicaid.

IV. REQUIRED ACTION

Effective July 1, 1997, social services districts must process applications for presumptive Medicaid eligibility in accordance with the procedures outlined in this ADM. Social services districts are required to make training available or to provide training to appropriate providers involved in the presumptive eligibility process.

A. APPLICATION

The DSS-2921, completed by the applicant or authorized representative, must be submitted to the social services district, with the physician's statement that the patient no longer requires care in an acute care hospital, but does require nursing facility, CHHA, LTHHCP, or hospice services. Included with the application package must be the completed Screening Checklist (Attachment I), the medical documentation from the hospital of the type of care and, in the case of CHHA services, the amount of care required.

Upon receipt of the application for presumptive Medicaid eligibility, the social services district must review the application package, including the Screening Checklist, to determine if the applicant meets the basic qualifying conditions to participate in the presumptive Medicaid eligibility program.

The social services district may ask questions to resolve conflicting information, particularly for items on the Screening Checklist. However, documentation cannot be required to determine presumptive Medicaid eligibility. Attestation of facts is sufficient to determine if an individual is presumptively eligible for assistance.

The social services district or its agent must agree that the CHHA or LTHHCP services recommended are appropriate. The social services district agent providing the evaluation of medical need might be a CASA or staff in the Medicaid or Long Term Care Unit. The social services district is neither expected nor required to visit or converse with the applicant or hospital staff at this time to evaluate medical need. The evaluation should be done from the written material provided by the hospital to explain the care required.

B. COST EFFECTIVENESS

The hospital must submit medical documentation of the type of care required. The hospital may use the suggested Medical Documentation Transmittal Form (Attachment II) to transmit this information to the social services district. Documentation of the type of care required should be sufficiently detailed to enable a social services district to evaluate the appropriateness of LTHHCP or CHHA services. In addition, documentation needs to be sufficiently detailed to enable the social services district to determine cost effectivness of CHHA services.

1. Home Care

If the applicant will be receiving the services of a CHHA, the social services district must multiply the hourly or visit rate for each home health service by the number of hours or visits the patient requires per month. This monthly amount is then divided by 30 days to determine the average daily cost. Sixty five percent of the average daily cost is then compared to the hospital's Medicaid alternate level of care rate to determine cost effectiveness. (The CHHA service rates are usually available from the Long Term Care Coordinator in the social services district.)

No cost comparison is required for persons who will receive their care through a LTHHCP, since in order to participate in the LTHHCP the cost of care in that program must be less than the cost of care in a skilled nursing facility.

2. Nursing Facility and Hospice Services

If the applicant will be receiving nursing facility services, the social services district must compare 65 percent of the average regional Medicaid nursing facility rate with the appropriate (Upstate or New York City/Metro Region) Medicaid alternate level of care rate to determine cost effectiveness. Attachment III lists the average regional Medicaid nursing facility per diem rates (at 100 percent and 65 percent), and the appropriate Medicaid alternate level of care rate to determine cost effectiveness. These rates will be updated annually by the Department.

To determine cost effectiveness of hospice services (whether provided to an individual residing in the community or to an institutionalized individual), the social services district must compare 65 percent of the average regional Medicaid nursing facility rate with the appropriate alternate level of care rate.

C. DETERMINATION OF PRESUMPTIVE ELIGIBILITY

The determination notice must be mailed within five working days of receipt of the presumptive eligibility application package or by the discharge date if that date is later. The social services district must then undertake a routine determination of the applicant's standard Medicaid eligibility. This includes scheduling an appointment for an interview with the applicant or the applicant's representative to present documentation to verify statements in the application.

If the applicant is determined not to be presumptively eligible, the social services district must send the "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services" (Attachment V) or "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility Services or Inpatient Hospice Care" (Attachment VI), whichever is appropriate, to the applicant (in care of the hospital if there is no authorized representative) and to the hospital, denying the application for presumptive Medicaid eligibility. Social services districts must reproduce Attachments V and VI without modification on social services district letterhead. The hospital should inform the affected provider of the denial of presumptive eligibility. Unless the applicant withdraws the application, the social services district must continue the process of determining the applicant's standard Medicaid eligibility.

In all instances, third party health insurance, including Medicare, must be maximized prior to any Medicaid payment.

V. ADDITIONAL INFORMATION

A. FAIR HEARING RIGHTS

Applicants who are denied presumptive eligibility benefits are not entitled to a fair hearing to challenge the denial. Applicants who are determined to be presumptively eligible and are subsequently determined to be ineligible for Medicaid will receive a standard notice of denial advising them of their right to a fair hearing. Such applicants are not entitled to aid continuing pending the issuance of a fair hearing decision.

B. REIMBURSEMENT FOR SERVICES

Once a standard eligibility determination is made, and the applicant is found eligible for Medicaid, the nursing facility, hospice, CHHA, or LTHHCP provider must submit an adjusted claim in order to receive the remaining 35 percent of the Medicaid rate(s). If the applicant is determined ineligible for Medicaid, the provider will not be paid the remaining 35 percent of the Medicaid rate(s) for services provided. However, the provider may seek payment of this amount from the applicant. In addition, any medical bills paid on behalf of the applicant during the presumptive eligibility period will be subject to recoupment from the applicant by the social services district.

C. FISCAL IMPLICATIONS AND PROCEDURES

As noted in earlier sections of this ADM, reimbursement made to the nursing facility, hospice, CHHA or LTHHCP provider during the period of presumptive eligibility will be at 65 percent of the amount billed and will be funded totally with State funds. Other covered medical services will be reimbursed at the full Medicaid rate with 100 percent State funds also.

If standard Medicaid eligibility is denied, the provider will not be paid the remaining 35 percent. Further, the 65 percent paid will be adjusted to the 81.24 percent State share, and 18.76 percent local share. The adjustment for the other covered medical expenses will be computed at 50 percent State and 50 percent local.

If the applicant is determined to be eligible for standard Medicaid, the provider will be permitted to bill MMIS for the remaining 35 percent portion. Funding for both the 65 percent paid and the remaining 35 percent will be recomputed and computed, respectively, at 50 percent federal, 40.62 percent State, and 9.38 percent local shares. For those payments made for other covered expenses, the funding will be recomputed to 50 percent federal, 25 percent State, and 25 percent local shares.

No action is required by the social services district to effect the adjustment to the funding.

D. AUDIT REQUIREMENTS

Cases determined to be presumptively eligible under these provisions will be subject to audit by the Department of Health. Thus, careful review of the unverified application information is required. SSL Section 364-i provides that if more than 15 percent of the cases determined presumptively eligible by a social services district are subsequently determined not to be eligible, the cost of their care shall be borne equally by the State and social services district rather than the 18.76 percent local and 81.24 percent State share.

E. REPORTING REQUIREMENTS

SSL Section 364-i requires a report to the Governor and the Legislature. The report must evaluate the program and include the program's effects on access, quality and cost of care, and any recommendations to improve the program. Social services districts must submit a report to the Department on the impact of this program in their districts on their operating procedures, including any indirect costs. While social services districts may submit this report in the format of choice, the Department would like the following areas to be addressed: impact on district operations, costs, and access and quality of care rendered to participants, and any recommendations to improve the program. The report must be sent by January 3, 2000, to:

Bureau of Medicaid Eligibility
Office of Medicaid Management
State Department of Health
P.O. Box 118, 1 Commerce Plaza
Albany, New York 12260

VI. SYSTEMS AND NOTICES PROCEDURES

The DSS-2921 must be registered for all applicants for presumptive eligibility.

Systems support will be available statewide on June 1, 1997.

A. UPSTATE

1. Applicant is Presumptively Medicaid Eligible

For those individuals determined to be presumptively Medicaid eligible, authorize an MA Case (Case Type 20) for 60 days beginning with the exact day presumptive eligibility begins. On Screen 3 enter Individual Categorical Code 35 (Presumptive Eligibility - Long Term Care), and State/Federal Charge Code 50 (Presumptive Eligibility - State Charge).

On Screen 5 the MA Coverage Dates extend for 60 days mirroring the Authorization period. The MA Coverage Code must be 08 (Presumptive Eligibility Long Term Care). The Principal Provider Code must equal blank, 00 (No Principal Provider), or 14 (Personal Care Service). And the card code cannot equal R (Roster). There is no need to produce a roster for billing during the period of presumptive eligibility.

In the Principal Provider Subsystem, the appropriate Principal Provider Code must be 01 (Private-Skilled Nursing), 02 (Private-Intermediate Care), 03 (Public-Skilled Nursing), or 04 (Public-Intermediate Care) to allow payment to the facility. The appropriate provider identification number, NAMI amount and Provider Exception Code must be entered. Follow standard procedures for Medicare maximization.

The social services district must send the "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services" (Attachment V) or "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility Services or Inpatient Hospice Care" (Attachment VI), whichever is appropriate. The social services district must send the notice of the client's eligibility to the applicant (in care of the hospital if there is no authorized representative), the hospital, and the proposed provider. In addition, the social services district must advise the provider of the client's liability toward cost of care, if applicable.

The presumptive eligibility period continues until either a standard Medicaid eligibility determination is made or 60 days from the date of discharge from the hospital, whichever occurs first. Issue a temporary Medicaid card upon notification that the recipient residing in the community needs ambulatory services before the Common Benefit Identification Card (CBIC) can be issued.

a. Recipient Subsequently Determined Eligible for Standard Medicaid

If the individual is determined eligible for standard Medicaid, an undercare transaction should be made. The State/Federal Charge Code should be removed and the Individual Categorical Code must be changed to reflect the individual's category of eligibility. The MA Coverage Code and corresponding MA Coverage Dates must be changed retroactively to the beginning of the standard Medicaid eligibility period, as appropriate. For nursing home cases, change the Principal Provider Code and the Card Code on Screen 5 to the appropriate codes. Issue a manual DSS-3622 "Notice of Decision on Your Medical Assistance Application," DSS-3973 "Notice of Decision on Your Medicaid Application (Excess Income)," or DSS-4022 "Notice of Intent to Establish a Liability Toward Chronic Care," as appropriate.

b. Recipient Subsequently Determined NOT Eligible for Standard Medicaid

If the individual is determined ineligible for standard Medicaid, the case should be closed on WMS using Reason Code Y91 (MA Ineligible After Period of LTC Presumptive Eligibility) with a Notice Indicator of N (No CNS Notice). The Authorization TO Date should be the day the case is closed and no change should be made to the MA Coverage TO Date. Send a manual denial DSS-3622 "Notice of Decision on Your Medical Assistance Application," or DSS-3973 "Notice of Decision on Your Medicaid Application (Excess Income)," as appropriate. The ten-day notice requirement is not applicable.

2. Applicant is NOT Presumptively Medicaid Eligible

If the applicant is not presumptively Medicaid eligible, and standard Medicaid eligibility has not yet been determined, send Attachment V or VI, whichever is appropriate, but do not enter the presumptive eligibility denial on WMS.

If the applicant is not presumptively Medicaid eligible, AND is not eligible for standard Medicaid, process the application as a standard Medicaid denial on WMS, with the appropriate CNS Denial Reason Code. In addition, you must send the "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services" (Attachment V) or "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility Services or Inpatient Hospice Care" (Attachment VI), whichever is appropriate, to the applicant (in care

of the hospital if there is no authorized representative) and the hospital.

If the applicant is eligible for standard Medicaid, open the case on WMS, and issue a manual DSS-3622 "Notice of Decision on Your Medical Assistance Application," DSS-3973 "Notice of Decision on Your Medicaid Application (Excess Income)," or DSS-4022 "Notice of Intent to Establish a Liability Toward Chronic Care," as appropriate, to the applicant (in care of the hospital if there is no authorized representative), the hospital, and the provider.

3. Presumptive Eligibility Notices/Systems Flowchart

Attachment IV is a reference tool which details in flowchart form the notices to use and WMS systems requirements.

B. WMS NEW YORK CITY

1. Applicant is Presumptively Medicaid Eligible

For individuals determined to be presumptively eligible for Medicaid, authorize an MA Case (Case Type 20). A Medicaid case can be authorized for a maximum of three months beginning with the first day of the month presumptive eligibility begins. Utilize Opening Code 086.

For proper identification of and claiming for these individuals, Categorical Code 35 (Presumptive Eligibility - Long Term Care) and State Charge/Federal Charge Code 50 (Presumptive Eligibility - State Charge) must be entered. SSI budgeting (MABEL BT 04 or 07) will be utilized for these recipients. The case must consist of no more than one active line. Employment code 27, 32, 70 or 74 must be entered.

The MA Coverage Code must be 08 (Presumptive Eligibility Long Term Care). Enter the specific dates of coverage in MA Coverage Code 08. The first day of coverage will be the exact day the individual is discharged from the hospital. The coverage end day may be a maximum of 60 days from the Coverage From Date. The coverage end day may be any valid calendar day.

When appropriate, input the applicable Principal Provider information. The Principal Provider Code must be 01 (Private-Skilled Nursing), 02 (Private-Intermediate Care), 03 (Public-Skilled Nursing), or 04 (Public-Intermediate Care) to allow payment to the provider. The appropriate provider identification number, NAMI amount and Provider Exception Code must be entered. Follow standard procedures for Medicare maximization.

The presumptive eligibility period continues until either a standard Medicaid eligibility determination is made or 60 days from the date of discharge from the hospital, whichever occurs first. Issue a temporary Medicaid card upon notification that the recipient

residing in the community needs ambulatory services before the CBIC card can be issued.

The social services district must send the "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services" (Attachment V) or "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility Services or Inpatient Hospice Care" (Attachment VI), whichever is appropriate. The social services district must send the notice of the client's eligibility to the applicant (in care of the hospital if there is no authorized representative), the hospital, and the proposed provider. In addition, the social services district must advise the provider of the client's liability toward cost of care, if applicable.

a. Recipient Subsequently Determined Eligible for Standard Medicaid

If the individual is ultimately determined eligible for standard Medicaid, the appropriate Categorical Code, MA Coverage Code and Coverage Period should be entered in the undercare transaction. The State/Federal Charge Code will change to 88 on the date of the transaction.

Issue the following applicable notices to the client or authorized representative, and the provider: MAP 2087K "Notice of Acceptance of Your Medical Assistance Application (Institutional Care/Nursing Homes);" MAP 2060C "Budget Explanation - Institutional Services;" or MAP 2087 "Notice of Decision on Your Medical Assistance Application."

b. Recipient Subsequently Determined NOT Eligible for Standard Medicaid

If the individual is ultimately determined to be ineligible for Medicaid, the case should be closed with Reason Code 198.

The particular presumptive program the individual applied for should be specified in the notice language, i.e., home health care, hospice care, or nursing facility care. Issue the MAP 2087A "Notice of Denial of Your Medical Assistance Application" to the client or authorized representative, and the provider.

2. Applicant is Not Presumptively Medicaid Eligible

Individuals who are determined to be inappropriate candidates for presumptive Medicaid eligibility should be denied. Denial Code 299 is appropriate.

Issue the "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Home Health or Community Hospice Care Services" (Attachment V) or "Notice of Decision on Your Presumptive Medicaid Eligibility Application for Coverage of Nursing Facility Services or Inpatient Hospice Care" (Attachment VI), whichever is

appropriate, to the applicant (in care of the hospital if there is no authorized representative) and the hospital.

Note: If sixty days elapse without the occurrence of an undercare transaction, the system will change the State/Federal Charge Code to 88 on the sixtieth day.

VII. EFFECTIVE DATE

The provisions of this ADM are effective July 1, 1997.

Ann Clemency Kohler, Director
Office of Medicaid Management

ATTACHMENT I

SCREENING CHECKLIST

MEDICAID PRESUMPTIVE ELIGIBILITY APPLICATION FOR
NURSING FACILITY, HOSPICE, OR HOME CARE SERVICES

DATE:	NAME AND ADDRESS OF HOSPITAL:
APPLICANT NAME (AND C/O NAME IF PRESENT) AND ADDRESS:	NAME OF HOSPITAL PERSONNEL COMPLETING THIS FORM (PLEASE PRINT): Telephone Number:

To be eligible to participate in the presumptive eligibility program, an individual must reasonably appear to be eligible for Medicaid. If ANY of the following boxes is checked YES, based on documentation or statements of the applicant (or authorized representative), the individual is NOT eligible to participate:

	YES	NO
The individual has insurance which fully covers the care he or she will be receiving upon discharge from the hospital for at least 60 days from the date of the presumptive eligibility application.	☐	☐
The individual is not a citizen, not a naturalized citizen, or not an alien who has been both lawfully admitted for permanent residence and was admitted prior to August 22, 1996, or has resided in the United States for at least five years.	☐	☐
The individual or the individual's non-applying spouse fails or refuses to make his or her income and/or resources available to the other spouse.	☐	☐
For spousal impoverishment cases, the couple's combined countable assets (excluding the home) exceed $78,270.	☐	☐
The individual (and/or spouse) is the grantor and/or beneficiary of a trust (except a burial trust).	☐	☐
The individual (and/or spouse) owns real property other than the home.	☐	☐
The individual (and/or spouse) transferred assets within the previous 36 months.	☐	☐
The individual is Home Relief-related (i.e., over age 21 and under age 65, and not certified blind/disabled).	☐	☐

Date: _____ ATTACHMENT II

PRESUMPTIVE MEDICAID ELIGIBILITY PROGRAM
MEDICAL DOCUMENTATION TRANSMITTAL FORM

TO: _____ FROM: _____

PATIENT NAME & ADDRESS:

_____

Social Security Number:

Estimated Date of Discharge from the Hospital:

Type of care needed:

+-+ Nursing Facility +-+ Inpatient Hospice +-+ Community Hospice +-+ LTHHCP +-+ CHHA

MONTHLY CHHA SERVICES NEEDED:

Type of Service: _____ Hrs/Visits Needed: _____ Frequency _____
Type of Service: _____ Hrs/Visits Needed: _____ Frequency _____
Type of Service: _____ Hrs/Visits Needed: _____ Frequency _____
Type of Service: _____ Hrs/Visits Needed: _____ Frequency _____

Proposed Provider Name and Address: _____ Medicaid ID#:

Contact Person:

Attachments:

+-+ Physician Statement
+-+ Programmatic Service documentation requirements (e.g., PRI, DMS-1)
+-+ Hospice Election Form
+-+ Other: _____

AVERAGE REGIONAL MEDICAID NURSING FACILITY PER DIEM RATES
AND UPSTATE AND NEW YORK CITY/METRO ALTERNATE LEVEL OF CARE RATES

Note: 65% of the per diem is provided in bold next to the per diem rate.

$123.53/$80.29
NORTHEASTERN

Albany
Clinton
Columbia
Delaware
Essex
Franklin
Fulton
Greene
Hamilton
Montgomery
Otsego
Rensselaer
Saratoga
Schenectady
Schoharie
Warren
Washington

$149.52/$97.19
NORTHERN METROPOLITAN

Dutchess
Orange
Putnam
Rockland
Sullivan
Ulster
Westchester

$114.27/$74.28
WESTERN

Allegany
Cattaraugus
Chautauqua
Erie
Genesee
Niagara
Orleans
Wyoming

$167.61/$108.95
LONG ISLAND

Nassau
Suffolk

$190.00/$123.50
NEW YORK CITY

Bronx
Kings (Brooklyn)
New York (Manhattan)
Queens
Richmond (Staten Island)

$127.77/$83.05
ROCHESTER

Chemung
Livingston
Monroe
Ontario
Schuyler
Seneca
Steuben
Yates
Wayne

$118.73/$77.17
CENTRAL

Broome
Cayuga
Chenango
Cortland
Herkimer
Jefferson
Lewis
Madison
Oneida
Onondaga
Oswego
St. Lawrence
Tioga
Tompkins

ALTERNATE LEVEL OF CARE (ALC) RATES

NEW YORK CITY/METRO REGION: $192.54

Bronx, Kings, New York, Queens,
Richmond, Nassau, Suffolk,
Westchester, Rockland

UPSTATE: $126.00

Rest of state

PRESUMPTIVE MEDICAID ELIGIBILITY

UPSTATE SYSTEMS AND NOTICES FLOWCHART