CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

MAP 4200

_____
DATE

_____
RECIPIENT NAME

_____
RECIPIENT ADDRESS

_____
AGENCY NAME

_____
AGENCY ADDRESS

Dear Coordinator:

Please be advised _____, social security number _____ meets the criteria for
APPLICANT NAME SS NUMBER
nursing facility admission and is approved for placement in the _____ waiver program.
WAIVER NAME
Should the individual meet the eligibility requirements for Medicaid benefits, the effective date for coverage for waiver services is _____ through _____.
BEGIN DATE END DATE
The individual's estimated cost for care is _____ per month. Any payment for continuance of
AMOUNT
service beyond this date will require a reassessment by the individual's provider and prior authorization by Medicaid.

For an individual that is not a Medicaid recipient, application for Medicaid benefits must be made at the local Department for Community Based Services (DCBS) office within thirty (30) days of the date of this letter.

If the individual is Medicaid eligible as "spend-down", contact should be made with the DCBS office to ascertain the potential for eligibility under the special income level provision. For individuals who meet the waiver service requirements and whose income does not exceed 300% of the SSI standard, a special income level is used in determining Medicaid eligibility. The special income provision is applicable only while the individual is eligible for and receiving waiver services.

Providers should not provide services based on this letter alone. You must see a form MAP 552, a Medicaid identification card for the period of service, and a prior authorization letter from Unisys.

Sincerely,

Healthcare Review Corporation

cc: DCBS Office
Waiver Provider if applicable

EDUCATION PAYS