New York Independent Assessor
New York State's Assessment Program in collaboration with New York Medicaid Choice

Assessment Request Form

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

SECTION 1. MEDICAID HEALTH PLAN INFORMATION

Current Medicaid Health Plan
Managed Long Term Care plan individual wants to join

SECTION 2. INDIVIDUAL'S IDENTIFYING INFORMATION

Last Name	First Name	MI	DOB (MM/DD/YYYY)
Medicaid CIN	Social Security Number	Telephone Number ☐ Landline ☐ Mobile	
Address (No. and Street)		City	
State	Zip Code	Email Address	

AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Last Name	First Name	MI	Relationship to Individual
Address (No. and Street)	City	State	Zip Code
Telephone Number ☐ Landline ☐ Mobile	Email Address		

A legally authorized representative for the purpose of sharing health information is defined as "a person or agency authorized by state, tribal, military or other applicable law, court order or individual's consent to act on 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

As explained by New York Independent Assessor (NYIA), I understand:

- 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.
- The differences between a Medicaid health plan and an MLTC plan.
- I may not be able to see my current doctors if I change to an MLTC plan.
- My assessment will determine my eligibility to join an MLTC plan. The NYIA will contact me to schedule the assessment.
- 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.

Individual's Name (please print)

Sign Here

Individual's Signature **Date**

Authorized Representative's Signature (if applicable) **Date**

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SECTION 4. HEALTH CARE PROVIDER AUTHORIZATION

A physician, nurse practitioner, or physician assistant must fill out this entire section.

I _____ hereby confirm that _____
Health Care Provider's Name — 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 _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Signature _____

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 ( ) _____