

DIVISION OF POLICY AND OPERATIONS

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/IDD 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/IDD 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

I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, ACQUIRED 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 intellectual or developmentally disability (ICF/IDD) level of care.

The recipient/legal representative must check their choice. Consideration for the waiver program as an alternative to ICF/IDD ***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 (ABI) waiver program is for individuals aged twenty-one (21) to sixty-five (65) that have sustained an aquired 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 Medicaid ID 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 Medicaid ID 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: