STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

March 1, 2016

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Long Term Care Service Provider:

RE: Medicaid Nursing Facility Services and the MI Health Link Program

This notification is being sent to providers of long term care services including nursing facilities, county medical care facilities, and hospital long term care units to provide clarification on the process involved with the submission of the Facility Admission Form (MSA-2565-C) for an individual enrolled in the MI Health Link program.

The MI Health Link program covers the custodial/long term nursing facility service benefit. When an individual who is enrolled in the MI Health Link program is admitted to a nursing facility for custodial/long term nursing services, **a disenrollment from the Integrated Care Organization (MI Health Link health plan) is NOT REQUIRED**. The Facility Admission Form (MSA-2565-C) should **NOT** be sent to the Michigan Department of Health and Human Services (MDHHS) Enrollment Services Section for a disenrollment to be processed.

When an individual enrolled in the MI Health Link program is admitted to a nursing facility for custodial/long term nursing services, the facility must submit the Facility Admission Form (MSA-2565-C) to **the local MDHHS office** in order for the appropriate MI Health Link level of care code to be entered into the appropriate systems.

If you have questions please contact the Integrated Care email box at INTEGRATEDCARE@michigan.gov.

Sincerely,

Chris Priest, Director
Medical Services Administration

enclosure

Michigan Department of Health and Human Services

FACILITY ADMISSION NOTICE (MSA-2565-C)

INSTRUCTIONS

GENERAL INSTRUCTIONS/DISTRIBUTION:

- The MSA-2565-C serves as notice of admission of a beneficiary (or potential beneficiary). It must be completed for potentially eligible Medicaid beneficiaries of all ages.

- The facility must retain **THE ORIGINAL** of the Facility Admission Notice in the beneficiary's file. A copy **MUST** be sent to the Local MDHHS Office.

- A copy of the MSA-2565-C will be returned to the facility, noting the eligibility status and patient pay amount of the resident.

Authority: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act
Completion: Is Voluntary
Penalty: None, but a medical eligibility determination would be delayed

Michigan Department of Health and Human Services

FACILITY ADMISSION NOTICE

1. Patient Name *(Last, First, Middle)*	2.Gender ☐ M ☐ F	3. Birth Date / /	4. Social Security No. - -
5. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
6. Name of Person Responsible for Patient *(Last, First, Middle)*	7. Phone No. ( ) -	8. Relationship to Patient	
9. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
10. Name of Provider	12. A. National Provider ID Number.	12. B. Provider I.D. Number	
11. Provider Address *(No. & Street)*	13. Attending Physician Name		
City / State / Zip Code	14. Hospital Case No. *(If Applicable)*		

15. Type of Facility *(Check ONE)*

☐ Hospital ☐ Long Term Care (in Hospital) ☐ Nursing Facility ☐ Psychiatric Care (in DCH Facility))
☐ Special IID Nursing Facility ☐ ICF/IID Care (in MDHHS Facility) ☐ Medical Care Facility
☐ Other (Explain) _____

16. Date of Admission / /	17. If LTC Facility, Specify Private Rate $ _____ per diem amount	18. Is this Admission Likely to be 30 days or Longer? ☐ NO ☐ YES (If YES, Estimate Total Length of Stay) _____

19. Present Status of Patient *(Check ONE)*

☐ Still a Patient ☐ Discharged (Date): / / ☐ Deceased (Date): / /

20. Primary Diagnosis	21. Secondary Diagnosis

22. Patient Admitted to Facility From: *(Check ONE)*

☐ Home ☐ Long Term Care Facility/Unit ☐ AFC/ Home for the Aged ☐ Other (Specify) _____
☐ Hospital (Enter applicable dates) Admission Date / / Discharge Date / /

23. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable

☐ Medicare ☐ No Other Insurance Coverage Available
☐ Private Health Insurance (Complete Items 24 thru 29 below) ☐ Private LTC Coverage (Complete Items 30 thru 35 below)

24. Name of MI Health Link Integrated Care Organization			31. MI Health Link Integrated Care Organization Provider I.D. Number		
25. Name of Policyholder (Private Health Ins.)	26. Policyholder's SS No. - -		32. Name of Policyholder (Private LTC Ins.)	33. Policyholder's SS No. - -	
27. Name of Insurance Company			34. Name of Insurance Company		
28. Location (City)	State	Zip Code	35. Location (City)	State	Zip Code
29. Group / Policy Number	30. Cert. / Contract No.		36. Group / Policy Number	37. Cert. / Contract No.	

PATIENT CERTIFICATION

I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section **10** above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

36. Signature of Patient or Patient's Representative Date Signed / /	37. Signature of Person Completing This Form Date Signed / /

STATEMENT OF ELIGIBILITY (To be completed by MDHHS for MA eligibility)

Eligibility is:

☐ **DENIED** (Contact Patient or Patient's Representative for Explanation) ☐ **APPROVED** (see the Billing Information below)

Eligible Person's Name	Program	Grantee Name				
Recipient ID No.	MA Eligibility Effective Date	Grantee Client ID No.				MDHHS Case No.
Patient Pay Amount $	Patient Pay Amt. Effective Date	County	District	Section	Unit	Worker Name
Insurance, Medicare, Third Party Name		Signature of Worker				

MSA-2565-C (5/15) Previous editions are obsolete.