



Date

ATTN: Admissions Coordinator

Eligibility Specialist/CCAD Caseworker

Office Address and Telephone No.

Notification of Receipt of Application

Name of Applicant	Application No. (if necessary)	Date of Application
-------------------	--------------------------------	---------------------

- RESIDENT** — The applicant listed above, who is a resident of your facility, has applied for Medicaid assistance. Please be sure that the Resident Transaction Notification and either the medical necessity (MN) determination or the level of care determination equivalent have been submitted.

Enter the 3 months prior to the Date of Application

the applicant may be eligible for retroactive benefits.

Your cooperation is appreciated. Please contact me if you have any questions.

- ATTENDANT CARE SERVICES** — The applicant listed above has been receiving attendant care services from your agency and has applied for retroactive payment. If you have not done so, please send a copy of the service plan for the months of:

Enter prior months

Your cooperation is appreciated. Please contact me if you have any questions.