

DISCHARGE NOTICE



MAP-259f (OHIP3563) 05/29/2020
(Replaces MAP-1124)

This form **MUST** be submitted at the actual time of discharge. Providers submitting manually must fax this form to (917) 639-0687. Providers using EDITS must submit through EDITS.

Date: 11/07/23

TO:

Medical Assistance Program
NHED - Expedited Discharge Unit
P.O. Box 24210
Brooklyn, NY 11202-9810

FROM:

NAME OF FACILITY Silvercrest ECF	
ADDRESS 144-45 87TH AVE JAMAICA, NY 11435	
PROVIDER NUMBER 01215512	
CONTACT PERSON Kim Cheek	TELEPHONE (718) 480-4020
EMAIL ADDRESS kcheek@silvercrest.org	

LAST NAME BATSON	FIRST NAME NADENE	CIN NA05517K
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☐ Consumer Expired Date of Death: _____

The above-named resident was discharged on 02/14/23 to the following: (check box below)
(Date)

☐ Out of State ☒ Own Home ☐ Relative's Home ☐ Intermediate Residential Alternative (IRA) ☐ Shelter
☐ Out of County ☐ ALP ☐ Congregate Care ☐ Hospital ☐ AWOL
☐ Adult Home ☐ Other (specify) _____

If the resident was discharged to another Nursing Home, use MAP-2159 form and submit to the Transaction Unit.

Address of above: 116-40 INWOOD STREET JAMAICA, NY Zip Code: 11436
Contact Person for new residence: CHRISTINE BATSON Telephone Number: (718) 825-2009

Dialysis services needed: ☐ Yes ☐ No If "yes", name of center: _____

Is the consumer enrolled in a Medicaid Managed Long-Term Care Plan or will be enrolled upon discharge? ☐ Yes ☒ No

Discharged to Own Home:

- ☐ Resident was notified of the availability of the Special Income Standard for housing expenses for individuals discharged from a nursing facility and who have enrolled in a Managed Long-Term Care (MLTC) Program.
- ☐ Check box if MAP-3057 was given or sent to the resident/consumer upon discharge.