MAP-INC Guide
(1/22)

Incarceration Status Correction Form Guide

**Please note that you should always check eligibility in KYHealthNet before providing services. If KYHealthNet shows the person presenting for services as incarcerated, the following actions are to be taken:

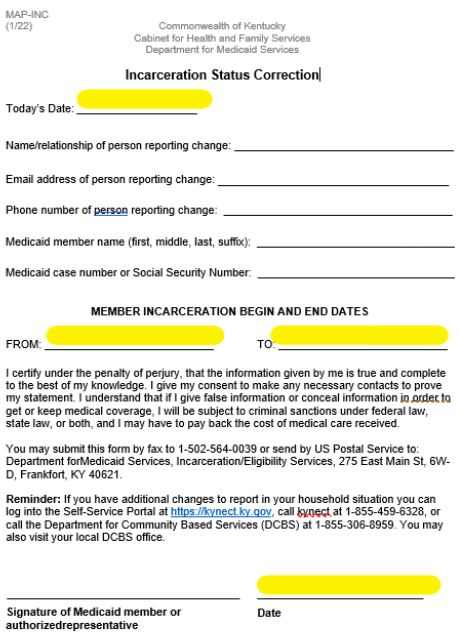
The member may complete the MAP-INC and fax it to Medicaid Member Services as 502-564-0039, to update eligibility or the member may log in to their KYNECT account to update their status.

-OR-

The provider may call Kentucky Medicaid Provider Services at 1-855-824-5615 to report the error.

The Incarceration Status Correction (MAP-INC) Form is used by the Department for Medicaid Services (DMS) to make corrections to the incarceration dates in a Medicaid member's case. If the form is not filled out correctly it will be considered incomplete. In this guide we will go over how to appropriately fill out the MAP-INC form. If the form is returned incomplete no changes will be made to the member's case.

Dates:



MAP-INC
(1/22)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Incarceration Status Correction

Today's Date: _____

Name/relationship of person reporting change: _____

Email address of person reporting change: _____

Phone number of person reporting change: _____

Medicaid member name (first, middle, last, suffix): _____

Medicaid case number or Social Security Number: _____

MEMBER INCARCERATION BEGIN AND END DATES

FROM: _____ TO: _____

I certify under the penalty of perjury, that the information given by me is true and complete to the best of my knowledge. I give my consent to make any necessary contacts to prove my statement. I understand that if I give false information or conceal information in order to get or keep medical coverage, I will be subject to criminal sanctions under federal law, state law, or both, and I may have to pay back the cost of medical care received.

You may submit this form by fax to 1-502-564-0039 or send by US Postal Service to: Department forMedicaid Services, Incarceration/Eligibility Services, 275 East Main St, 6W-D, Frankfort, KY 40621.

Reminder: If you have additional changes to report in your household situation you can log into the Self-Service Portal at https://kynect.ky.gov, call kynect at 1-855-459-6328, or call the Department for Community Based Services (DCBS) at 1-855-306-8959. You may also visit your local DCBS office.

_____ _____

Signature of Medicaid member or authorizedrepresentative **Date**

On the MAP-INC, there are four different areas where dates need to be filled out:

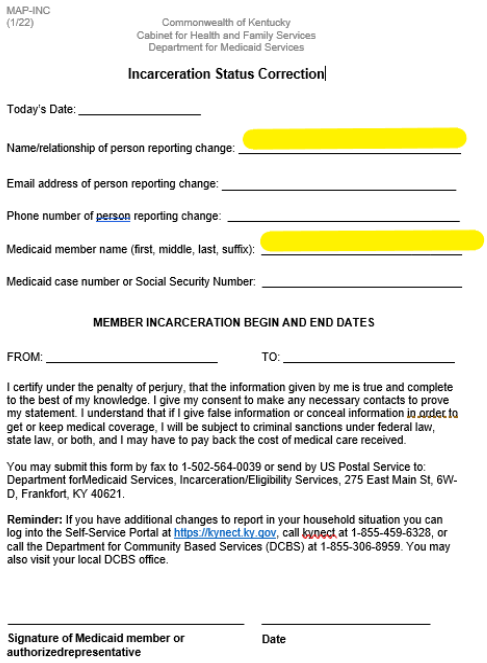
*The date the form was filled out or current date.

*The member's incarceration begin and end dates.

*The date the form is signed.

All dates must include the month, day, and year. Without this information the form will be considered incomplete and the change will not be made.

Names:



MAP-INC
(1/22)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Incarceration Status Correction

Today's Date: _____

Name/relationship of person reporting change: _____

Email address of person reporting change: _____

Phone number of person reporting change: _____

Medicaid member name (first, middle, last, suffix): _____

Medicaid case number or Social Security Number: _____

MEMBER INCARCERATION BEGIN AND END DATES

FROM: _____ TO: _____

I certify under the penalty of perjury, that the information given by me is true and complete to the best of my knowledge. I give my consent to make any necessary contacts to prove my statement. I understand that if I give false information or conceal information in order to get or keep medical coverage, I will be subject to criminal sanctions under federal law, state law, or both, and I may have to pay back the cost of medical care received.

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_____ _____

Signature of Medicaid member or authorizedrepresentative **Date**

On the MAP-INC, there are two different areas where names are required:

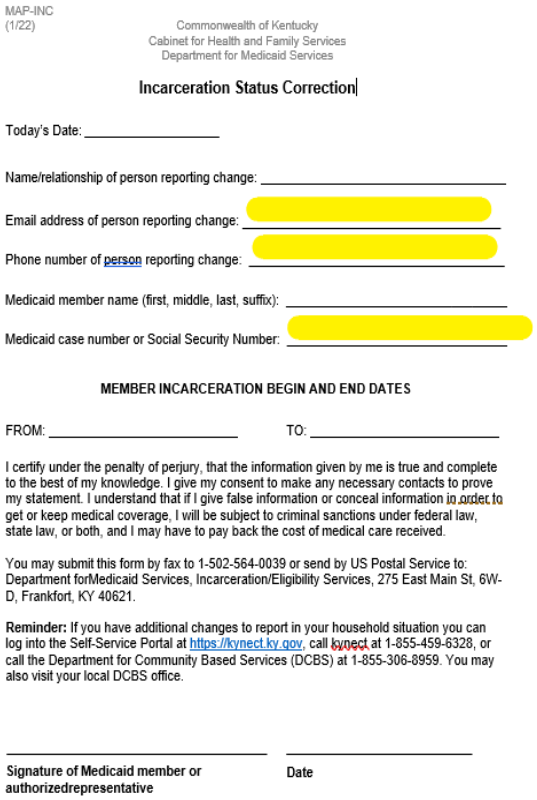
*Name of person reporting status change.

*Member name (first, middle, last & suffix).

The Medicaid member who was incarcerated can also be the person reporting status change.

It is important to note that **both** the person reporting name and the member name areas must be filled out. Without this information the form will be considered incomplete and the change will not be made.

Phone Number, Email, Medicaid Case Number or Social Security Number:



MAP-INC
(1/22)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Incarceration Status Correction

Today's Date: _____

Name/relationship of person reporting change: _____

Email address of person reporting change: _____

Phone number of person reporting change: _____

Medicaid member name (first, middle, last, suffix): _____

Medicaid case number or Social Security Number: _____

MEMBER INCARCERATION BEGIN AND END DATES

FROM: _____ TO: _____

I certify under the penalty of perjury, that the information given by me is true and complete to the best of my knowledge. I give my consent to make any necessary contacts to prove my statement. I understand that if I give false information or conceal information in order to get or keep medical coverage, I will be subject to criminal sanctions under federal law, state law, or both, and I may have to pay back the cost of medical care received.

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_____ _____

Signature of Medicaid member or authorizedrepresentative **Date**

On the MAP-INC form, there are important information sections:

*Phone number of the person reporting the change.

*Email address of the person reporting the change.

*Medicaid case number or social security number.

It is important to include the phone number and email address of the person reporting the change. DMS may have questions, or the form may be incomplete, which could delay or prevent processing. This information will allow DMS to notify the person reporting the change if an error has been found with the form.

The Medicaid case number or member's Social Security Number is required to access the correct individual to make the requested changes. Without this information the form will be considered incomplete and the change will not be made.

Signature:

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Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Incarceration Status Correction

Today's Date: _____

Name/relationship of person reporting change: _____

Email address of person reporting change: _____

Phone number of person reporting change: _____

Medicaid member name (first, middle, last, suffix): _____

Medicaid case number or Social Security Number: _____

MEMBER INCARCERATION BEGIN AND END DATES

FROM: _____ TO: _____

I certify under the penalty of perjury, that the information given by me is true and complete to the best of my knowledge. I give my consent to make any necessary contacts to prove my statement. I understand that if I give false information or conceal information in order to get or keep medical coverage, I will be subject to criminal sanctions under federal law, state law, or both, and I may have to pay back the cost of medical care received.

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Reminder: If you have additional changes to report in your household situation you can log into the Self-Service Portal at https://kynect.ky.gov, call kynect at 1-855-459-6328, or call the Department for Community Based Services (DCBS) at 1-855-306-8959. You may also visit your local DCBS office.

_____ _____

Signature of Medicaid member or authorizedrepresentative **Date**

On the MAP-INC form, there is only one signature section:

*Signature of Medicaid member or authorized representative.

The authorized representative must be verified within the member's Medicaid case to be considered a valid signature.

DMS will mark the MAP-INC form incomplete if anyone other than the Medicaid member or the authorized representative signs the form. Without this information the form will be considered incomplete and the change will not be made.

There are three different ways to submit the completed MAP-INC form to DMS:

*Fax to 1-502-564-0039

* Send by US Postal Service to:
Department for Medicaid Services
Incarceration/Eligibility Services
275 East Main St, 6W-D
Frankfort, KY 40621

*Email to DMS.ELIGIBILITY@ky.gov

If you have additional changes to report in your household situation log into the Self-Service Portal at https://kynect.ky.gov, contact kynect at 1-855-459-6328, or call the Department for Community Based Services (DCBS) at 1-855-306-8959. You may also visit a Department for Community Based Services (DCBS) office.