Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

August, 31, 2015

Mailings of Notices to All Excess Income Consumers

In our May 18, 2015 Alert entitled Surplus Payments by Third Parties, we notified organizations assisting consumers with Medicaid coverage in the Surplus Pre-Payment Program (Pay-in) that these payments can only be authorized when payment is made using a recipient's net available excess income.

A notice was recently sent to all Medicaid Excess Income (Surplus and Pay-in) clients providing them with this information as well as the client attestation form (MAP 3107a). This form can be used when payments are made by third parties to affirm that the recipient's funds were provided to be used for the payment. The notice provided information that was intended only for Pay-In consumers who meet their excess (surplus) by making payments directly to Human Resources Administration's (HRA) Division of Accounts Receivable and Billing (DARB). The information in the notice applies only to consumers who have a third party make their payments.

Consumers and agencies that submit paid or unpaid medical bills, including those from public programs (e.g. ADAP and OPWDD) in order to satisfy the consumer's excess income are not affected by this notice. Consumers can continue to fax their paid or unpaid medical bills to the S-Fax Unit at 917 639-0645, and approved surplus submitting agencies can continues to submit their medical bills directly to the Surplus unit.

For further information on Surplus payments by Third Parties please refer to the May 18, 2015 Alert.

PLEASE SHARE THIS ALERT WITH ALL APPROPIATE STAFF

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
Medical Assistance Program• Office of Eligibility Information Services • 785 Atlantic Avenue, Brooklyn, NY 11238
Steven Banks, *Commissioner* **Karen Lane,** *Executive Deputy Commissioner* **Maria Ortiz-Quezada**, *Director of EIS*

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MEDICAID ALERT

May 18, 2015

Surplus Payments by Third Parties

The purpose of this Alert is to advise organizations assisting consumers that Medicaid coverage under the Surplus Pre-Payment Program (Pay-In) can only be authorized when payment is made using a recipient's own net available excess income. Payment must be made by the recipient or a legally responsible third party (guardian, power of attorney, etc.) using the recipient's own funds. Please note, checks from a joint-checking account, even if signed by the non-recipient account holder, will be treated as the recipient's own funds. Legally responsible third parties can either submit legal documentation as proof of status or completed MAP 3107a (sample below). To help ensure easy access to this form, it has also been posted on HRA's internet site at: http://bit.ly/hrasurplusattestation and may be accessed by clicking on the first link underneath "Other Information" .

In the event that anyone other than the recipient, legally responsible relative, non-recipient joint account holder or legally responsible third party submits a payment on behalf of a recipient, s/he must complete MAP 3107a (Attestation Form), affirming that the recipient's funds were provided to him/her to be used for the payment. Parties who will need to complete an Attestation Form include but are not limited to: adult children, siblings, neighbors, friends, etc.

- For example, a recipient who does not have a checking account could give cash in the amount of her/his net available excess income to her/his adult child and have that child write a check to HRA DARB (HRA's Division of Accounts Receivable and Billing). The recipient must submit a completed copy of the Attestation Form, signed by the adult child, to the Medical Assistance Program.

Legally responsible third party documentation (guardianship orders, power of attorney forms, etc.) and/or Attestation Forms should be mailed to the Medical Assistance Program at least two weeks in advance of the first submission of a payment by a third party in order to prevent any delays in processing. This submission is only required before the first payment that is made on behalf of the recipient by that third party. It will be maintained on file and referenced for any future surplus

payment that is made on the recipient's behalf by that third party. If proper documentation is not submitted to support the submission of payment by a third party, the payment will be returned, which may impact the recipient's Medicaid coverage.

Third party documentation must be submitted to:

Medical Assistance Program
Surplus Division
P.O. Box 24390
Brooklyn, NY 11202-9814
Fax Number: 718 636-7720

Checks should still be made payable to HRA DARB (HRA's Division of Accounts Receivable and Billing) and submitted to:

HRA DARB
150 Greenwich Street, 34th Floor,
New York, NY 10007

We are preparing a mailing with this information and the attestation form to consumers currently participating in either the surplus or pay-in programs.

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ATTESTATION OF USE OF RECIPIENT FUNDS

NYC Human Resources Administration
Department of Social Services

MAP-3107a (MLF) 05/05/2015

I,_____, swear or affirm that, the funds used to support any and all
(Your Name)

Surplus Program payments made from my accounts on behalf of _____
(Name of Medicaid Recipient/Surplus Program Applicant)

_____were provided to me by the above named recipient.
(Case Number)

My relationship to the Medicaid Recipient is _____

In signing this attestation, I certify that the statements above are true, correct, and complete with the full understanding that failing to tell the truth could result in loss of benefits for the above Medicaid recipient.

(Your Signature)		(Date)
(Your Street Address)		
(Your City, State and Zip Code)		
(Your Telephone Number)		

Yo,_____, juro o afirmo que, los fondos usados para financiar cualquiera y todos
(Su nombre)

los pagos del Surplus Program hechos de mis cuentas en nombre de _____
(Nombre del Beneficiario de Medicaid/Solicitante del Surplus Program)

_____me fueron proporcionados por el beneficiario arriba mencionado.
(Número de caso)

Mi relación con el Beneficiario de Medicaid es _____

Al firmar esta atestación, certifico que las declaraciones que aparecen arriba son verdaderas, correctas y completas con total entendimiento de que no decir la verdad podría resultar en pérdida de beneficios para el beneficiario de Medicaid antes mencionado.

(Firma)		(Fecha)
(Dirección)		
(Ciudad, estado y código postal)		
(Su número de teléfono)		

本人 _____ 宣誓並確認，用於支援任何及所有
(您的姓名)

剩餘額計畫付款的資金，均來自於代表 _____
(Medicaid 領用人/剩餘額計畫申請人姓名)

_____的本人帳戶，且為由上方列名的領用人提供給我。
(個案號碼)

我與 Medicaid 領用人的關係為 _____

在此證明書上簽名，即表示本人確認上述敘述真實無誤，且本人完全瞭解若陳述不實可導致上述 Medicaid 領用人失去其福利。

(您的簽名)		(日期)
(您的街道地址)		
(您的城市、州及郵遞區號)		
(您的電話號碼)		

Mwen, _____, sèmante oswa konfime, lajan mwen itilize pou sipòte nenpòt ak tout
(Non Ou)

Peman Pwogram sipli ki fèt nan kont mwen yo sou non _____
(Non Benefisyè Medicaid/Moun ki Aplike pou Pwogram Sipli)

Benefisyè ki gen non li endike anwo a te ban mwen _____.
(Nimewo Dosye)

Relasyon mwen avèk Benefisyè Medicaid se _____

Depi mwen siyen atestasyon sa a, mwen konfime deklarasyon ki endike anwo a se deklarasyon ki vrè, kòrèk, ak konplè, epitou si mwen pa di laverite sa kapab lakòz benefisyè Medicaid ki endike anwo a pèdi avantaj l ap resevwa yo.

(Siyati Ou)		(Dat la)
(Adrès Kay ou)		
(Vil, Eta, ak Kòd Postal ou)		
(Nimewo Telefòn ou)		

Я, _____ (ваше имя), подтверждаю, что средства, используемые для осуществления всех платежей по программе Surplus Program с моих счетов от имени _____ (Имя получателя услуг Medicaid / кандидата на получение услуг в рамках программы Surplus Program) _____ (номер дела), были предоставлены мне вышеуказанным получателем.

Я прихожусь получателю услуг Medicaid _____

Подписывая настоящее подтверждение, я подтверждаю, что приведенные выше сведения являются правдивыми, верными и полными, полностью понимая, что сокрытие или искажение достоверных сведений может привести к лишению пособия вышеуказанного получателя услуг Medicaid.

(ваша подпись)	(дата)
(ваш адрес: улица, дом, квартира)	
(ваш город, штат, индекс)	
(ваш номер телефона)	

본인, _____ (본인 이름) (은)는

_____ (Medicaid 수령인/잉여 프로그램 신청인 이름) _____ (케이스 번호)

(을)를 대신해 본인의 계좌에서 일부 및 모든 잉여 프로그램 지급을 지원하기 위해 사용된 자금이 상기 수령인에 의해 본인에게 제공되었음을 맹세 또는 단언합니다.

Medicaid 수령인에 대한 본인의 관계는 _____입니다.

이 증명서에 서명함으로써 본인은 진실을 말하지 않는 경우 상기 Medicaid 수령인의 혜택이 상실될 수 있음을 완전히 이해하며 위의 진술이 진실이며 정확하고 온전함을 증명합니다.

(서명)	(날짜)
(도로 주소)	
시, 주, 우편번호	
전화번호	

رقأُ _____ وكل أيًا من معدل تمدختسمُلا لاومألا نأ دكؤأ وأ،
(اسمك)

من حسابي بالنيابة عن تـعفـد مدفوعات برنامج الفائض التي _____
(اسم مقدم طلب برنامج فائض الدخل/مُتلقي تغطية Medicaid)

دُفعت لي من قبل المُتلقي المذكور أعلاه _____
(رقم الحالة)

علاقتي بمُتلقي Medicaid _____ يه

صصاتبتوقيعي على هذا التصديق، أقر بصحة ما ذَكِر أعلاه وبأنها حقيقية ومكتملة وأتفهم تمامًا أن عدم البوح بالحقيقة قد يؤدي إلى فقد مخ مُتلقي Medicaid المذكور أعلاه.

(التاريخ)		(توقيعك)
(عنوان شارعك)		
(مدينتك وولايتك والرمز البريدي)		
(رقم هاتفك)		