Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

May 11, 2017

Revised Disabled, Aged, Blind (DAB) Renewal Form *and* On-line Reprints of DAB Renewal Form

The purpose of this Alert is to inform Client Representatives, Providers, Community Based Organizations and all other entities assisting disabled, aged, and blind (DAB) clients with their renewals that, beginning this month, HRA will mail a revised DAB renewal form. The form has been revised to comply with Medicaid policy changes as well as to improve clarity and readability for consumers. A sample of the revised form is attached.

The DAB renewal form will continue to be pre-printed with the client's case information. This pre-printed form must be used for the renewal process. It is very important that consumers carefully review all of their information and update as appropriate, or check "No Change" if the pre-printed information remains current. All renewals must be signed. Unsigned renewals will be returned for a signature.

With the introduction of this renewal form, DAB renewals will be made available for reprint on ACCESS NYC. Users can go to www.nyc.gov/accessnyc. From the landing page, once users have logged into an existing account or created a new account, they can navigate to the Medicaid Renewal page to view/reprint their renewal. This functionality is available for DAB renewals with a notice date of May 2017 or later. Earlier DAB renewals are not available via ACCESS NYC for reprint.

As a reminder, non-DAB renewals were already available for reprint on ACCESS NYC. Consumers can also request a reprint of their renewal be mailed to them by calling HRA's InfoLine (718) 557-1399.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
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Steven Banks, *Commissioner* **• Maria Teresa Arce,** *Chief External Affairs Officer* **•Maria Ortiz-Quezada***, Director of EIS*

RENEWAL NOTIFICATION

LOCATION:
NOTICE DATE:
CASE NUMBER:
NUMBER OF ADULTS:
NUMBER OF CHILDREN:
PRIORITY:
RVI CODE:
TELEPHONE NUMBER:

Dear Consumer:

It is time to renew your Medicaid / Managed Long Term Care / Medicare Savings Program (MSP / QMB). Renewal instructions are attached to help you. **Complete and sign** this form and attach all required proofs. Return your entire renewal form, **including this page.**

You must respond **before < insert date – snippet 1f >** or your coverage may end**.** If your coverage ends, depending on the coverage that you have now, we will no longer be able to provide you with health insurance coverage or pay your Medicare premium, deductible or co-pays.

Review the form carefully. If anything is wrong or has changed, write in the correct information. If it is correct, check the "**No Change**" box.

If you moved from New York City to another county within New York State, but a new case has not yet been opened where you now live, you should complete this form and we will make sure your renewal gets to your new local district.

You **must provide** certain "proofs" supporting the information you provide on this form:

- Proof of any change in your immigration status, if you are reporting a new status;
- Proof of any change in your health insurance other than Medicare, including any change to the premium that you pay;
- If you are blind or disabled, proof of disability-related work (non-medical) expenses, if any;
- If you are enrolled in the Medicaid Buy-In Program for Working People with Disabilities;
  - proof of current employment; **or**
  - a letter stating that you lost your job within the last six months either because of a change in medical condition or through no fault of your own (for example, you were laid off).

If you have a Pooled Trust in which you have made deposits, provide proof of all deposits made since the date you applied for Medicaid or your last renewal (whichever is most recent). For proof of these deposits, you must provide one of the following:

- An accounting statement or signed letter from the Pooled Trust Administrator confirming receipt of the deposits
- Copy of bank statements showing direct debits or cleared checks to the Pooled Trust
- Copy of cancelled checks to the Pooled Trust

If you have a Pooled Trust for which you have not submitted a Joinder Agreement, you must provide a copy of the Joinder Agreement for approval by the Human Resources Administration, Office of Legal Affairs.

RESERVED FOR BARCODE

1. **HOUSEHOLD INFORMATION:** This section is printed with the names of family members on your case.
   - Update the information if it is wrong or if it has changed.
     - If there is no change in household, check the "No Change" box.
   - If **"ADD SSN"** is printed in the "Social Security Number" column, write in your/your household member's Social Security Number.
   - If "**NUMBER ON FILE**" is printed in the "Social Security Number" column, we already have the SSN.
   - If "**SEND PROOF**" is printed in the "Citizenship/Immigration Status" column, or your immigration status has changed, send the most recent letter received from the federal immigration agency or other proof of current immigration status.
     - If you are declaring that you are a U.S. citizen, place a **"C"** in the "Citizenship/Immigration Status" column.
   - You do not need to send proof of citizenship at this time. If proof is needed, you will receive a letter requesting it.

	Household Members	Date of Birth	Sex (M/F)	Social Security Number	Citizenship/ Immigration Status	No Change
1						**[ ]**
2						**[ ]**
3						**[ ]**

2. **ADDRESS WHERE YOU LIVE**: **(No Proof Required)**

	No Change **[ ]**
Secondary Address for Notices (if provided)	No Change **[ ]**
Housing/Rent Payment: How Often?	No Change **[ ]**

3. **MEDICARE HEALTH INSURANCE**: (No Proof Required for Medicare Part A or Part B. However proof of your Part C (Medicare Advantage Plan) premium, if any, is required. This may be used to reduce your Medicaid income.

Premium Amount	No Change
	[ ]
	[ ]

4. **OTHER HEALTH INSURANCE:** (Provide proof of payment for any health insurance premium cost other than Medicare Part A or Part B. This may be used to reduce your Medicaid income.)

Other Health Insurance ☐Yes ☐No **If Yes**, write-in name of insurance company. below:	Amount of Premium	How Often (example: weekly, monthly)	No Change
_____	_____	_____	[ ]
_____	_____	_____	[ ]

5. **INCOME:** If you need to upgrade your coverage to include Community-Based Long Term Care Services (for example Managed Long Term Care), or if you expect to be eligible for Medicaid with a surplus, provide proof of income.

Name	Type of Income	Name of Employer (if income is from employment)	Amount before taxes and deductions	How Often (weekly/bi-weekly/ monthly)	No Change
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]

6. **RESOURCES**: (No Proof Required Unless Indicated Below)

Resources include cash on hand, savings and checking accounts, certificates of deposit, stocks, bonds, trust funds, 401Ks, mutual funds, ownership of a business, property that you or someone in your family owns, etc. **Do not list your home**.

If you do not have any resources, please write "NONE" under "Resource Type(s) in the table below. If your resources have changed from what is printed below, please update the list.

Resource Type(s)	Resource Amount	No Change
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]

A. Do you own real estate/real property other than your primary residence? ☐ Yes ☐ No
If Yes, provide the information requested below.

Address of Property:_____

Value of Property: _____

Income Received from Property: $_____ How Often _____

Do you own or co-own your home? ☐ Yes ☐ No **If Yes**, is your **home equity value** (the market value of the home or the portion of the home that you own, less all mortgages, liens and other debts against the home) more than $ **insert snippet 5a ?** ☐ Yes ☐ No

7. POOLED TRUST DEPOSITS (Provide Proof of Deposits)

Pooled Trust Deposit Amount	How Often

8. CHILDCARE/DEPEDENT CARE EXPENSES (No Proof Required)

Childcare/Dependent Care Expense Amount	How Often

9. PREGNANCY AND DISABILITY: Provide proof of disability-related work expense in order to reduce your Medicaid income. No proof related to a pregnancy for any family member is required.

Is anyone on your Medicaid case pregnant? ☐ Yes ☐ No.

If Yes, who is pregnant? _____

If Yes, what is the expected date of delivery? _____

If anyone on this case is blind or disabled, do they have to pay special expenses (non-medical) in order to work? ☐ Yes ☐ No

If Yes:

Work Related Expense	How Often

10. VISUAL DISABILITY: (No Proof Required)

If you have a visual disability that makes reading this notice difficult, we are working to provide many of our notices to you in large print, audio cd, data cd or Braille. If you would like notices to be sent to you in one of these formats as they become available, just check one of the boxes below:

☐ Large Print ☐ Data CD

☐ Audio CD ☐ Braille

Also, fill in below:

The language that I speak is: _____

The language that I read is: _____

We have written notices in English, Spanish, Arabic, Chinese (Traditional), Haitian-Creole, Korean and Russian.

Please be sure that you answered all the questions on this form, in all the sections. **Remember to sign Page 7.**

Mail this completed form and all required documentation in the enclosed postage paid envelope **before** the "respond before" date printed on Page 1.

(Remainder of page left blank intentionally)

I certify under penalty of perjury that everything on this application is the truth, as best I know. This includes the Financial Maintenance at Renewal information that I may have chosen to provide at this time by completing Page 8 of this Renewal Notification. I have also read and understand the Terms, Rights and Responsibilities.

I understand that this information is used to determine continuing eligibility for public health insurance programs. I also understand that if I intentionally misrepresent my situation, I may have to repay the cost of benefits received and may be subjected to prosecution to the fullest extent of State and Federal law.

SIGN HERE

Signature of Consumer / Representative:

_____ Date:_____

Signature of Legally Responsible Relative / Spouse or Representative (if applicable):

_____ Date:_____

If you are married, both you and your spouse must sign.

Navigators and other third party external organizations (if assisting the consumer) must read the following and sign below.

By having signed this Renewal Notification, I certify that the information reported on this form was provided solely by the applicant/recipient. This includes the Financial Maintenance at Renewal information that s/he may have chosen to provide at this time by completing Page 8 of this Renewal Notification. I did not modify the information in any way. I understand that if I intentionally falsified information on this form or if I assisted the applicant/recipient in falsifying any information, I may lose my job and be prosecuted to the fullest extent of State or Federal law.

FOR EXTERNAL ORGANIZATION USE ONLY: To be completed by the organization, if any, assisting with this Renewal Form

Employer's Name: _____

Worker's Name (print): _____

Worker's Signature: _____

Date Signed: _____

Financial Maintenance at Renewal

Important Notice: You must fill out this form only if your share of monthly housing expenses is more than 70% of your gross monthly income. Most consumers are **not required** to complete this form.

For example: If you are earning $1,000 per month with rent/mortgage of $500 per month, you are only spending 50% ($500 of $1000) of your monthly income on housing, and you **do not need to** complete this form. But, if you are earning $1,000 per month with rent/mortgage of $800 per month, you are spending 80% ($800 of $1000) of your monthly income on housing, and **you must** complete this form.

If you know that this form applies to you, please complete and sign it now. If you are unsure whether this form applies to you, you can choose to either complete the form now or leave it blank. If you leave it blank and we determine that it is required from you, we will send you another form. We will suspend our processing of your case for up to 14 days while we await your response. If we **do not** receive your response within those 14 days, we will not be able to renew your coverage and your case will be **closed.**

Monthly Living Expenses	Explanation of Expenses
If you have any of the following monthly living expenses, please check (☑) the box and write in the monthly amount spent on each item.	Explain how you pay for each of your monthly living expenses (such as cash on hand, checking/savings account monies, income/wages, credit cards, help from others). List the name and relationship to you of anyone providing help. If the expense has not been paid, please make a note of this and indicate how long it has not been paid.

☐	Rent/Mortgage/ Property Taxes	$_____	
☐	Water	$_____	
☐	Childcare	$_____	
☐	Cable	$_____	
☐	Phone	$_____	
☐	Heat	$_____	
☐	Electricity	$_____	
☐	Food	$_____	
☐	Transportation	$_____	
☐	Credit Card Payments	$_____	
☐	Other	$_____	

Total Monthly Living Expenses $ _____ Total Gross Monthly Income $ _____