Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

April 9, 2018

Asset Verification System (AVS)

The purpose of this Alert is notify organizations assisting consumers with Medicaid applications and renewals of the implementation of the Asset Verification System (AVS) for purposes of determining Medicaid eligibility for SSI related applicants and recipients (A/Rs). This system has already been implemented for all applications and renewals in the rest of New York State. HRA is in the process of implementing AVS in New York City.

The New York State Department of Health (SDOH) contracted for the creation of an asset verification system (AVS) to be in compliance with federal requirements. This AVS allows for electronic exchange of financial account information with national and local financial institutions, and real property information with public records databases.

Initial implementation by HRA began in October 2017 with new applications submitted through EDITS by 25 nursing homes for non-spousal applications. Effective January 22, 2018, use of AVS was expanded to all non-spousal new Nursing Home applications submitted through EDITS. Effective Monday, March 26th, the use of AVS was again expanded to include new spousal Nursing Home applications submitted through EDITS. We will send out further Alerts as AVS is implemented for additional application types.

Information Available Through AVS

Generally, AVS will electronically verify accounts held in banking institutions and conduct searches on real property owned by the A/R and/or the A/R's spouse during the month of application and the three-month retroactive period.

For individuals applying for Medicaid coverage of nursing home care, AVS will:

- Verify the A/R's and the spouse's accounts held in banking institutions for the month of application and the 60-months look-back period, including accounts that were closed during this period and will identify months in which a potential transfer of assets is detected; and
- Conduct searches on real property owned by the A/R or the A/R's spouse during the month of application and the 60-months look-back period, including any property that was sold or transferred during the period.

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Paper Documentation

Paper documentation of Resources is required:

- If AVS does not return a response for a bank account that was reported on Supplement A, and the individual is applying for community –based long-term care or nursing home care
    - Since we do not yet know the response rate for AVS, we highly recommend continuing to submit paper documentation for bank accounts when they are available
- To further review transactions in months in which AVS identifies a potential transfer of assets
- For assets that cannot be verified through AVS. AVS only reports on financial accounts held in banking institutions and cannot be used to verify stocks, bonds, securities, and mutual funds purchased through a brokerage firm or life insurance policies and annuity products issued by insurance companies
- In certain circumstances if there is a discrepancy between information provided by the A/R and the results of the AVS inquiry

Authorization to Verify Assets through AVS

An SSI-related A/R and his/her spouse must authorize the electronic verification of their assets as a condition of Medicaid eligibility. This requirement applies regardless of whether an applicant is attesting to the value of resources for community coverage without long term care or seeking Medicaid coverage of community-based long-term care or nursing home care. Exceptions to this requirement are:

- Incapacitated Individuals who are not capable of authorizing the verification of assets through AVS and who do not have another person authorized to sign on their behalf. **When submitting applications for incapacitated consumers, the MAP-3044 must be completed and submitted with the application.** Paper documentation of resources will be required for these consumers.
- Parents of SSI-related children are not required to provide AVS authorization since resources owned by the parents are not always considered in determining the child's eligibility. Paper documentation of resources will continue to be required if applicable.
- An SSI-related A/R (and his/her spouse) who are eligible for Medicaid Extended Coverage as a NYS Partnership for Long Term Care (NYSPLTC) policy holder with Total Asset Protection are not required to provide AVS authorization.
- Institutionalized Individuals in the Modified Adjusted Gross Income (MAGI) category of assistance may, but are not required to, provide AVS authorization for purposes of reviewing resources for the 60-months look-back period for coverage of nursing home care. If authorization is not provided, paper documentation of resources for the look-back period will be required.

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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How AVS is Authorized

The A/R's signature on the Medicaid application and renewal form is sufficient authorization to verify assets through AVS. A legally responsible spouse is required to provide authorization for Medicaid to electronically verify his/her assets as a condition of eligibility for an SSI-related A/R. This authorization must be signed by the legally responsible spouse or by someone authorized to act on the spouse's behalf. Supplement A (DOH-4495A) has been modified to obtain a non-applying spouse's authorization to verify assets through AVS. This new form is the Supplement A (DOH-5178A). At this time, HRA continues to use the DOH-4495A but we will accept the DOH-5178A if it is submitted. SDOH has also created a new form the DOH-5149 for purposes of obtaining the signature of a non-applying spouse. Spousal Nursing Home applications must include either the DOH-5178A or the DOH-4495A and the DOH-5149. Renewal forms will be modified to obtain non-applying spouse information and signature when HRA implements AVS for renewals.

If a Medicaid application is signed by someone other than the applicant, the applicant's spouse, or an authorized representative, a separate authorization must be submitted to allow the individual to sign the application on behalf of the applicant. For Nursing Home cases, the MAP-3043, **Authorization to Apply for Medicaid on My Behalf**, can be used to document this authorization as well as the signature page of the Master Admissions Agreement (for those facilities already pre-approved by HRA's Office of Legal Affairs). Additionally, the MAP-3044A, Facility Submission on Behalf of a Client must be included with the submission.

Medicaid applications filed on behalf of deceased persons must be signed by the decedent's surviving spouse or by the legally appointed representative of the decedent's estate. Applications received by HRA that are not signed by the decedent's spouse or estate representative will be accepted, but will be deferred for signature of the spouse or legally appointed representative. If the Medicaid application is signed by the decedent's spouse or estate representative, the decedent's assets can be verified through AVS.

Applications without appropriate signatures will be denied.

In most instances, HRA will be budgeting the resource information provided by AVS. If coverage is denied or discontinued due to excess resources, clients will be given 30 days to dispute these results.

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Access NY Supplement A

This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.
  This includes care in a hospital that is equivalent to nursing home care

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

INSTRUCTIONS:

- **Sections A through F must be completed and this Supplement must be signed.**
- **If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections G through I.**

SAMPLE

A. This Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Social Security Number	Marital Status

Note: The remaining questions are for the person(s) named above.

B. Blind, Disabled or Chronically Ill

1. Are you chronically ill? ☐ Yes ☐ No
   (Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)

2. Are you Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
   (If yes, send proof.)

3. If you are disabled and working, are you interested in applying for the MBI-WPD program? ☐ Yes ☐ No
   The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

C. Are you living in an adult home or assisted living facility? ☐ Yes ☐ No

D. Resources/Assets (check the box that applies):

☐ You are applying for Medicaid coverage but not coverage of community-based long-term care services. You may attest to the amount of your resources. You are not required to submit documentation of your resources. This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☐ You are applying for coverage of community-based long-term care services. You must submit documentation of the current amount of your resources.* These services include:

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

Note: Some examples of home and community-based programs that provide waivers and other services are Traumatic Brain Injury Program and Long Term Home Health Care Program.

☐ You are institutionalized and applying for coverage of nursing home care. You must submit documentation of your resources back to February 1, 2006, or the past 60 months, whichever is less.

* You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

SAMPLE

List all resources owned by you and/or your spouse/parent(s), including custodial accounts. **If applying for coverage of nursing home care,** also list any accounts closed since February 1, 2006, or in the past 60 months, whichever period is shorter; include balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more. **Note:** Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs):

Bank Name and Account Number	Name of Owner(s)	Current Dollar Amount	Closed Account Balance/ Date Closed
		$	$
		$	$
		$	$
		$	$
		$	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh):

Account Number	Name of Owner(s)	Type/Institution	Current Dollar Amount	Pay Out
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

3. Life Insurance Policies:

Insurance Company	Policy Number	Name of Owner(s)	Cash Value	Face Value
			$	$
			$	$
			$	$
			$	$
			$	$

4. Annuities, Stocks, Bonds, Mutual Funds:

Name of Owner(s)	Company	Date Purchased	Value
			$
			$
			$
			$
			$
			$
			$

5. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the schedule of trust assets.

Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			$		$
			$		$
			$		$

6. Burial Assets/Burial Contracts: (Include copies)

Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have money in a bank account set aside for a burial fund? ☐ Yes ☐ No

If **yes**, in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		$
		$
		$

Do you have life insurance to be used as your burial fund? ☐ Yes ☐ No

If **yes**, what is your policy number(s)? _____

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

Does your spouse have life insurance to be used as a burial fund? ☐ Yes ☐ No

If **yes**, what is the policy number(s)? _____

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles.

Name of Owner(s)	Year/Make/Model	Fair-Market Value	Amount Owed	In Use?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

SAMPLE

8. Equity Value in Home:

If you own your home, what is the equity value in your home? $ _____

Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

9. List Any Other Resources:

Resource Type	Name of Owner(s)	Value
		$
		$
		$
		$
		$
		$

E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply) ☐ Yes ☐ No

☐ Rental Property	☐ Vacation Property	☐ Time Share	☐ Vacant Land	☐ Other Property Rights (In or outside of New York State)

If **yes,** please answer the following questions:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$

SAMPLE

F. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No
2. If you are in a medical facility and own your home, do you intend to return to your home? ☐ Yes ☐ No
3. If **no,** is anyone living in the home? ☐ Yes ☐ No

Who is living in the home? _____

How is this person related to you and/or your spouse? _____

If you and/or your spouse's child (of any age) is living in the home, is the child disabled? ☐ Yes ☐ No

Note: If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility.

STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, the last page of this document MUST be signed.

G. Applicant Living in a Long-Term Care Facility/Nursing Home

Name of Facility	Date Admitted / /	Telephone Number ( )	
Street Address	City	State	Zip
Applicant's Previous Address	City	State	Zip

H. Asset Transfers

1. Transfers

a. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

b. Are you in the process of selling property? ☐ Yes ☐ No

c. Did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No
If **yes,** when? _____

d. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

e. Did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No
If **yes,** when? _____

f. Did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No
If **yes,** when? _____

2. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust? ☐ Yes ☐ No

If you answered yes to any of the questions above, explain the transfer(s) below.
Attach additional sheets of paper, if needed.

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			$
			$
			$
			$

3. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? **If yes, send copy of agreement.** ☐ Yes ☐ No

I. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No
If yes, send copies of these returns.

SAMPLE

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within the transfer of assets look-back period (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and determined otherwise eligible for Medicaid coverage of nursing facility services, may cause the individual to be ineligible for nursing facility services for a period of time.

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse on or after February 8, 2006, may be treated as a transfer unless:

- **The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or**
- **The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.**

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

SAMPLE

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

X _____
SIGNATURE OF APPLICANT/REPRESENTATIVE

X _____
DATE SIGNED

X _____
SIGNATURE OF APPLICANT'S SPOUSE

X _____
DATE SIGNED

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Medicaid Enrollment and Exchange Integration

Authorization for Verification of Resources (Legal Spouse)

This form authorizes Medicaid to request records from financial institutions for the **spouse** of an individual applying for Medicaid.

This Authorization must be signed by the applicant's spouse if the applicant is:

- Age 65 or older
- Certified blind or certified disabled (of any age)

Please complete all sections and sign the authorization.

Signing this Authorization is a condition of receiving Medicaid benefits. This is because eligibility depends on the amount of resources owned by the applicant and the applicant's spouse. **Failure to sign and submit this Authorization may result in a denial or discontinuance of Medicaid benefits.**

SAMPLE

I. INFORMATION FOR APPLICANT

Applicant's Name | Last Name | First Name | Middle Initial |

Social Security Number ___ – ___ – ____ Date of Birth ___ – ___ – ____

II. INFORMATION FOR APPLICANT'S SPOUSE

Spouse's Name | Last Name | First Name | Middle Initial |

Maiden Name or Other Name Known By

Social Security Number ___ – ___ – ____ Date of Birth ___ – ___ – ____

Address | Number | Street | Apt. Number |

| City | State | ZIP Code |

III. AUTHORIZATION

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid for my spouse.

This authorization will end if my spouse's application for Medicaid is denied, or my spouse is no longer eligible for Medicaid, or I revoke this authorization in a written statement to my local Department of Social Services.

Signature of Applicant's Spouse/Legal Representative* _____

Date Signed _____

**Note: If a legal representative is signing this authorization, also include the legal document giving him/her authority to act on behalf of the spouse.*

Supplement A

(Supplement to Access NY Health Care Application DOH-4220)

This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.
  This includes care in a hospital that is equivalent to nursing home care.

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

INSTRUCTIONS:

- Sections A through E must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections F through G.

SAMPLE

A. Applicant and Spouse Information

1. Applicant(s) this Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Marital Status	Social Security Number	Date of Birth	If Deceased, List Date of Death
					/ /	/ /
					/ /	/ /

Is a person named above:

- Chronically ill? ☐ Yes ☐ No
  (Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)

- Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
  (If yes, send proof.)

- Interested in applying for the MBI-WPD program if disabled and working? ☐ Yes ☐ No
  The Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

If an applicant is living in a long-term care facility/nursing home, adult home, or assisted living facility, provide the following information.

Name of Applicant who is in Facility	Name of Facility	Date Admitted / /	Telephone Number ( ) -
Street Address	City	State	Zip Code
Applicant's Previous Address	City	State	Zip Code

If the above previous address was also a facility or adult home, list the address prior to admission below.

Applicant's Second Previous Address	City	State	Zip Code

2. Applicant's Spouse: (if not listed above)

Legal Last Name	Legal First Name	MI
Maiden Name or Other Name Known By:	Social Security Number	Date of Birth / /
Street Address (if in a facility, list spouse's address prior to being admitted to facility)		
City	State	Zip Code

Is the applicant's spouse living in a long-term care facility/nursing home? ☐ Yes ☐ No

If **yes**, provide the following information:

Name of Facility	Date Admitted / /	Telephone Number ( ) -

Street Address	City	State	Zip Code

Is the applicant's spouse deceased? ☐ Yes ☐ No If **yes**, what is the date of death? _____ / _____ / _____

SAMPLE

B. What Care and Services are you Applying for? (check the box that applies)

☐ **You are applying for Medicaid coverage but not coverage of community-based long-term care services.** You may attest to the amount of your resources. You are not required to submit documentation of your resources at this time. If a computer match shows something different than what you reported, you may be asked to submit proof at a later date.

This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☐ **You are applying for coverage of community-based long-term care services.** Documentation of the **current** amount of your resources is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

This coverage includes the following services:*

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long term care in the community
- Waiver and other services provided through a home and community-based waiver program

Note: Some examples of home and community-based programs that provide waiver and other services are Traumatic Brain Injury Program and Nursing Home Transition and Diversion Program.

☐ **You are institutionalized and applying for coverage of nursing home care.** Documentation of your resources for the **past 60 months** is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

*You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 60-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

SAMPLE

DOCUMENTATION REQUIREMENTS

If you are requesting coverage for **community-based long-term care services** or **nursing home care,** provide documentation for the time period indicated above for all of the following resources, if applicable.

- Life insurance policy;
- Securities, stocks, bonds, and mutual funds;
- Annuities;
- Burial agreement or fund;
- Trust document and accounts.

You do not need to send proof of any other resources at this time. This is because other resources may be verified through computer matches. If the resources you report do not match our records or cannot be verified through our records, we may ask you to submit proof of those other resources at a later date.

C. Resources/Assets

INSTRUCTIONS FOR SECTIONS 1 THROUGH 8:

- List all resources currently owned by you and/or your spouse/parent(s), including custodial accounts.
- Check the **"NONE"** box if you and/or your spouse/parent(s) do not own any of those resources.
- **If applying for coverage of nursing home care,** also list any accounts CLOSED in the **past 60 months;** include the balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more.
  Note: Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs): ☐ NONE

Bank Name	Account Number	Name of Owner(s)	Current Account Balance	Closed Accounts	
				Date Closed	Balance at Closing
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh): ☐ NONE

Institution Name	Account Number	Name of Owner(s)	Pay Out	Current Account Balance	Closed Accounts	
					Date Closed	Balance at Closing
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$

3. Annuities, Stocks, Bonds, Mutual Funds: ☐ NONE

Institution/Company Name	Account Number	Name of Owner(s)	Date Purchased	Current Value	Closed Accounts	
					Date Closed or Sold	Value at Closing
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$

SAMPLE

4. Life Insurance Policies: ☐ NONE

Insurance Company	Policy Number	Name of Owner(s)	Current Cash Value	Current Face Value	Cancelled Policies	
					Date Cancelled	Cash Out Value
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$

5. Burial Assets/Burial Contracts: (Include copies): ☐ NONE

a. Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☐ Yes ☐ No

b. Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☐ No

c. Do you and/or your spouse have money in a bank account set aside for a burial fund? ☐ Yes ☐ No

If **yes,** in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		$
		$
		$

d. Do you have life insurance to be used as your burial fund? ☐ Yes ☐ No

If **yes**, what is your policy number(s)? _____

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

e. Does your spouse have life insurance to be used as a burial fund? ☐ Yes ☐ No

If **yes**, what is the policy number(s)? _____

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

SAMPLE

6. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the current schedule of trust assets. ☐ NONE

Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			$		$
			$		$
			$		$
			$		$

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles. ☐ NONE

Name of Owner(s)	Year/Make/Model	Fair Market Value	Amount Owed	In use?	Date Sold
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /

8. List Any Other Resources:

Resource Type	Name of Owner(s)	Value
		$
		$
		$
		$
		$
		$

D. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No
2. If you are in a medical facility and own your home, do you intend to return to your home? ☐ Yes ☐ No

   If **no,** is anyone living in the home? ☐ Yes ☐ No

   Who is living in the home? _____

   How is this person related to you and/or your spouse? _____

   If you and/or your spouse's child (of any age) is living in the home, is the child disabled? ☐ Yes ☐ No

   Note: If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility. **Send proof of legal impediment.**
3. Equity Value in Home:
   If you own your home, what is the equity value in your home? _____
   Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply) ☐ Yes ☐ No

☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights (In or outside of New York State)

If **yes,** provide the following information:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$

STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, Section I of this document MUST be signed.

SAMPLE

F. Asset Transfers

1. Transfers

a. In the last 60 months, did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

b. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust? ☐ Yes ☐ No

If you answered yes to either of the questions above, explain the transfer(s) below. Attach additional sheets of paper, if needed.

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			$
			$
			$
			$

c. Are you in the process of selling property? ☐ Yes ☐ No

d. In the last 60 months, did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No

If **yes,** when? _____

e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

f. In the last 60 months, did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No

If **yes,** when? _____

g. In the last 60 months, did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No

If **yes,** when? _____

2. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? ☐ Yes ☐ No

If yes, send copy of agreement.

G. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No

If yes, send complete copies of these returns including all schedules and attachments.

SAMPLE

H. Important Information

Liens on Real Property

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

Transfer of Assets

Federal and State laws provide that an individual may be found ineligible for nursing facility services for a period of time if an individual or an individual's spouse transfers an asset for less than fair market value within the look-back period. The look-back period is the 60 months immediately prior to the date an individual is both institutionalized and has applied for Medicaid.

Annuities

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse within the look-back period, may be treated as a transfer unless:

- The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or
- The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

SAMPLE

I. Certification and Authorization

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

If eligibility depends on the amount of my and my spouse's resources, by signing this application we authorize verification of our resources with financial institutions for the purpose of determining eligibility. Both spouses must sign below. This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Social Services.

X _____
SIGNATURE OF APPLICANT/REPRESENTATIVE

X _____
DATE SIGNED

X _____
SIGNATURE OF APPLICANT'S SPOUSE

X _____
DATE SIGNED

AUTHORIZATION TO APPLY FOR MEDICAID ON MY BEHALF

NYC Human Resources Administration Department of Social Services

MAP-3043 (E-S) 03/01/2018

I. FACILITY AND CONSUMER INFORMATION

A. Consumer Information:

Consumer's Name _____ SSN (last four digits) _____

Date of Birth _____ Sex _____ Telephone Number_____

Community Address _____

_____

B. Facility Information:

Facility Name _____

Address _____

_____

SAMPLE

II. REASON FOR SUBMISSION

I authorize the facility named above and its employees to represent me in the Medicaid application and/or renewal process. I authorize the release of necessary information/documentation between the NYC Human Resources Administration/Medical Assistance Program and this facility in regard to my application and/or continuing eligibility.
.

Signature of Consumer _____ Date Signed _____

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

AUTORIZACIÓN PARA SOLICITAR LA COBERTURA DE MEDICAID EN MI NOMBRE

NYC Human Resources Administration
Department of Social Services

MAP-3043 (E-S) 03/01/2018

I. INFORMACIÓN DEL CENTRO Y DEL CLIENTE

A. Información del cliente:

Nombre del cliente _____ SSN (últimos cuatro dígitos) _____

Fecha de nacimiento _____ Sexo _____ Número de teléfono _____

Dirección de la comunidad _____

_____

B. Información del centro:

Nombre del centro _____

Dirección _____

_____

SAMPLE

II. MOTIVO DE LA SOLICITUD

Autorizo al centro que se indica arriba y a sus empleados a que me representen en el proceso de solicitud/renovación de Medicaid. Autorizo la divulgación de información/documentación necesaria entre la Administración de Recursos Humanos de la Ciudad de Nueva York (NYC Human Resources Administration)/el Programa de Asistencia Médica (Medical Assistance Program) y este centro en relación con mi solicitud o elegibilidad continua.

Firma del cliente _____ Fecha de la firma _____

¿Padece usted una discapacidad o afección médica o psiquiátrica? ¿Le dificulta la misma entender o cumplir este aviso? ¿Le dificulta la afección recibir otros servicios de la HRA? **Nosotros podemos prestarle ayuda.** Llámenos al 212-331-4640. Usted también puede pedir asistencia al visitar las oficinas de la HRA. Conforme a la ley, usted tiene el derecho de solicitar este tipo de ayuda.

FACILITY SUBMISSION OF APPLICATION ON BEHALF OF CONSUMER

NYC Human Resources Administration Department of Social Services

MAP-3044a (E) 09/21/2016

I. FACILITY AND CONSUMER INFORMATION

A. Facility Information:

Facility Name _____ Submission Date _____

Address _____

_____

First and Last Name of Representative **(Print Clearly)**

_____

Title _____ Telephone Number_____

B. Consumer Information:

Consumer's Name _____ SSN (last four digits) _____

Date of Birth _____ Sex _____ Telephone Number_____

Community Address _____

_____

SAMPLE

II. REASON FOR SUBMISSION

If you are signing a Medicaid application on behalf of your consumer you must include **either** a signed authorization from the consumer **or** attest that the client is incompetent or incapacitated. One of the following must be checked and a copy of the authorization attached.

- ☐ Guardianship papers
- ☐ Power of Attorney
- ☐ MAP-3043**, Authorization To Apply For Medicaid On My Behalf**
- ☐ Signature page from pre-approved master admission agreement by the HRA's Office of Legal Affairs that includes the consumer's authorization to sign and submit a Medicaid application.
- ☐ Other written authorization (specify) _____

_____