Human Resources Administration
Department of Social Services

Medical Assistance Program (MAP)

MEDICAID ALERT

December 16, 2021

Medical Assistance Program Request for Information form MAP-751v

This Alert is to advise Medicaid Providers, Hospitals, Client Representatives, Community Based Organizations, Advocates, that the Medical Assistance Program began a mass mailing to all Disabled, Aged, and Blind (DAB) consumers including those in receipt of Managed Long Term Care, Homecare, MSP only, and Stenson (former SSI) that had their Medicaid case automatically extended during the COVID health emergency in 2021. The program is sending forms MAP-751v and from MAP 751K (see attached).

During this unprecedented emergency, no one with an active Medicaid case lost or will lose their health coverage.

If consumers have experienced any of the changes below during the COVID health emergency, please advise them of this mailing and, if necessary, assist them in submitting the information that needs to be changed. The mailing will include a business return envelope. The form asks for changes such as:

- Change in Residential or Mailing Address
- Alternative Format/Visual Impairment: If the client has a visual disability that makes reading notices difficult, we can provide many of our notices to consumers in the following formats:

  ♦ Large Print ♦ Audio CD ♦ Data CD ♦ Braille

- Language Read/Spoken: The program has written notices available in the following languages:

  ♦ English ♦ Spanish ♦ Arabic ♦ Bengali
  ♦ French ♦ Haitian Creole ♦ Korean ♦ Polish
  ♦ Russian ♦ Simplified Chinese ♦ Traditional Chinese ♦ Urdu

Once information is provided and the program processes any requested updates, a notice will be sent to the consumer regarding any action taken on their case.

If you have any questions related to these items, please call the Medicaid Helpline at **888-692-6116** or HRA Infoline at **718-557-1399**.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

Human Resources Administration
Department of Social Services

MAP-751v 04/13/2021

Request for Information

Dear Consumer:

During the COVID Health Emergency, no one with active Medicaid will lose their health coverage.

If one or more of the following changes has occurred during the COVID Health Emergency, complete the attached form and return it in the enclosed envelope.

- **Change in Residential or Mailing Address**
- **Alternative Format/Visual Impairment**
  - If you have a visual disability that makes reading notices difficult, we are working to provide many of our notices to you in the following format:
    - ♦ Large Print ♦ Audio CD ♦ Data CD ♦ Braille
- **Language Read/Spoken**
  - We have written notices available in the following languages:
    - ♦ English ♦ Spanish ♦ Arabic ♦ Bengali
    - ♦ French ♦ Haitian Creole ♦ Korean ♦ Polish
    - ♦ Russian ♦ Simplified Chinese ♦ Traditional Chinese ♦ Urdu

If you have any questions, call the **Medicaid Helpline at 888-692-6116**.

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 **888-692-6116**. 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.

CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE

(No Documentation Required)

Human Resources Administration
Department of Social Services

MAP-751k (E) 03/15/2021
Replaces MAP-751, MAP-751a, and MAP-3069b

Case Name: _____

Case Number: _____ CIN: _____

Change is for: _____

A. CORRECT/ADD THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

☐ **Change Name**

From: _____

To: _____

☐ **Correct Date of Birth**

From: _____

To: _____

☐ **Correct Gender Information**

From: _____

To: _____

☐ **Change Residency Address**

From: _____

To: _____

☐ **Change Mailing Address**

From: _____

To: _____

☐ **Add/Change Secondary Mailing Address**

From: _____

To: _____

☐ **Add/Correct Social Security Number (SSN)**

From: _____

To: _____

☐ **Add/Change Phone Number**

From: _____

To: _____

CORRECT/ADD THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

Language Spoken

☐ **Language Spoken** From: _____ To: _____

Language Read

We have notices available in the following languages:

- English
- Spanish
- Arabic
- Bengali
- French
- Haitian Creole
- Korean
- Polish
- Russian
- Simplified Chinese
- Traditional Chinese
- Urdu

Tell us what language you want your notices sent to you.

☐ **Language Read** From: _____ To: _____

Alternative Format/Visual Impairment

Do you have a visual disability that makes reading notices difficult? We can give you notices in the following formats. Tell us how you want your notices sent to you.

☐ **Large Print** ☐ **Audio CD** ☐ **Data CD** ☐ **Braille**

B. PROVIDER INFORMATION (TO BE COMPLETED BY PROVIDERS ONLY)

Note: This section is not to be used for Home Care Services Program Providers submissions.

Provider Name: _____

Provider Address: _____

Provider Code: _____ Original Determination Date: _____

Admission Date: _____ Admission Number: _____ Discharge Date: _____

Phone Number: _____ Fax Number: _____

NAME (PRINT)	SIGNATURE	DATE

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 **888-692-6116**. 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.