*Organization Letterhead*

*[note to user – this letter can be adapted for an individual SNT instead of a pooled trust*]

DATE

NYC Human Resources Administration (or county DSS)

Medical Assistance Program

*[add if client receiving home care/MLTC]* Home Care Services Program

785 Atlantic Ave.

Brooklyn NY 11238

**BY CERTIFIED MAIL #** **[XXXX]** or **FAX – Select one (delete the others)**

\_\_\_\_\_\_ [*If submitted with Application* **917-639-0732 general public   
 or 917-639-0731** C-REP unit]

\_\_\_\_\_\_\_ [If submitted with Immediate Need application **(917) 639-0665**]

\_\_\_\_\_\_\_ [*If submitted as rebudgeting request for current recipient* **1-917-639-0837]**

RE: [CLIENT NAME] (SSN: [SSN]) CIN (if known)

[Application with Pooled Trust]

[Rebudgeting Request re Pooled Trust for current recipient]

Dear Medicaid Eligibility Worker,

I am writing on behalf of my client, [CLIENT NAME] (“the consumer”), regarding his/her [application for][request to rebudget] Medical Assistance by deducting deposits into a Pooled Supplemental Needs Trust [“pooled income trust” or SNT].

The Consumer is a beneficiary of a Pooled Supplemental Needs Trust (SNT) maintained by [TRUSTEE ORGANIZATION]. The Consumer was accepted to this trust in [START DATE]. See Acceptance Letter and Joinder Agreement. The trust is a valid pooled supplemental needs trust pursuant to section 1917(d)(4)(C) of the Social Security Act and section 366(2)(b)(2)(iii) of the New York Social Services Law. See Master Trust. Because he/she is disabled, the income contributed monthly to this trust should be deducted from countable income.

**CONSUMER is DISABLED as required** under one of the following three options (check one).

1\_\_\_\_\_ Consumer is under age 65 and receives Social Security Disability benefits – see attached verification

2\_\_\_\_\_\_ Consumer is age 65 or greater, and prior to turning age 65 received Social Security Disability benefits, which were converted to Retirement benefits at age 65. See attached verification.

3\_\_\_\_\_\_\_ Enclosed, please find a completed Disability Determination Request form (MAP-3177), which we ask you to forward to the State Disability Review Unit in Albany for a disability determination. See GIS 12 MA/027; 05 OMM/INF-1. NYC HRA Medicaid Alert May 31, 2022 - *Disability Determination by NYS Disability Review Team (DRT) - Change in Forms Required*. Upon the request of that unit, we will submit the required proof of disability to that unit.

**REBUDGETING OF INCOME** with deposit of income to trust – for Medicaid and MSP

The Consumer has gross income of $0.00/mo. Since [START DATE], the Consumer has been contributing $0.00 each month to his/her SNT, which consumer intends to continue. See Verification of Deposits. Accordingly, the Consumer’s countable income is only $0.00/mo. (after the $20 disregard for unearned income and any other deductions), making him/her eligible for Medicaid with a spend-down of $0.00. {optional – The proposed budget is attached hereto)(use Excel worksheet at <http://health.wnylc.com/health/download/829/>)

Accordingly, the Consumer’s monthly contributions of income to the pooled trust account should be deducted from countable income. Once the NYS DRU determines disability, please [budget][re-budget] the Consumer’s Medicaid case with a spend-down of $0.00 effective [START DATE].

**QMB Medicare Savings Program Requested.** In addition, the deduction of the Consumer’s contributions to the pooled trust make him/her eligible for the QMB Medicare Savings Program. Accordingly, please enroll the Consumer in the QMB MSP retroactively to [START DATE].

Please do not hesitate to contact me at [PHONE] with any questions regarding this request. Thank you for your prompt attention to this matter.

Very Truly Yours,

[ADVOCATE'S NAME]

SIGNATURE BLOCK

Enclosures – see next page

ENCLOSURES:

1. Pooled Trust Acceptance Letter
2. Joinder Agreement, Signed
3. Master Trust
4. Verification of Deposits
5. Request for Determination of Disability – MAP 3177 [OR verification of SSD]
6. OCA Form 960 – Authorization for Release of Health Information Pursuant to HIPAA
7. [optional – Proposed budget with deposit to trust – suggested use <http://health.wnylc.com/health/download/829/>]
8. *If this is a rebudgeting request for a current Medicaid recipient --MAP-751W Consumer/Provider Request to Change Information on File (download at* [*https://www1.nyc.gov/assets/hra/downloads/pdf/services/health/MAP-751W.pdf*](https://www1.nyc.gov/assets/hra/downloads/pdf/services/health/MAP-751W.pdf)*) or in other languages at* [*https://www.nyc.gov/site/hra/help/health-assistance.page*](https://www.nyc.gov/site/hra/help/health-assistance.page)*)*