**APPLICANT/RECIPIENT DECLARATION CONCERNING THE LEGALLY RESPONSIBLE RELATIVE'S INCOME/RESOURCES**

NYC Human Resources Administration Department of Social Services

MAP-2161 (E) 05/11/2018

DATE: _____

CASE NAME: _____

CASE NUMBER: _____

**If you have any questions, call HRA Helpline at 888-692-6116**

Dear _____

This form is to be completed by the applicant or recipient who is living with a Legally Responsible Relative (LRR) who has refused to make income and/or resources available for the cost of necessary medical care and services. Legally Responsible Relatives are: spouses (e.g. husband for wife, wife for husband) and parents for children under 21.

The Legally Responsible Relative is not absolved from providing financial resources for the care of his or her spouse or child. The Department of Social Services expects the legally responsible relative to cooperate with the process of substantiating the income and resources of the responsible relative in order to determine the amounts the Legally Responsible Relative will be required to pay**. Legally Responsible Relatives may be taken to court for failure to support their spouses or minor children**. Failure to provide requested financial information may also result in the legally responsible relative being taken to court.

Complete the table below, including your signature and the date, and return this entire form in the enclosed envelope within 10 days

I (Print name) _____ _____ declare that my
(First) (Last)

☐ Spouse ☐ Parent ☐ Other, specify: _____
has refused to make his/her income and/or resources available for the cost of necessary medical care and services. I have read the above and understand that the process of financial review and collection of my Medicaid debt from my legally responsible relative begins when I sign this form.

Name of Legally Responsible Relative: _____ _____
(First) (Last)

Social Security Number of Legally Responsible Relative:_____

In consideration of the determination of my eligibility for Medical Assistance, I hereby assign, to the Commissioner of the New York City Human Resources Administration (Department of Social Services), my right of support from the legally responsible relative named above.

Name of Legally Responsible Relative's Health Care Plan (if applicable)

Type of Health Care Coverage (i.e. Long-Term Care): _____

Policy Number (if applicable): _____

Contact Number: ( )_____
(Area Code)

Signature of Applicant/ Recipient: _____ Date: _____

| Worker's Name | Title | Section |
|---|---|---|
| | | |

| Supervisor's Name (Print) | Supervisor's Name (Sign) |
|---|---|
| | |

**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.

**DECLARATION OF THE LEGALLY RESPONSIBLE RELATIVE**

Human Resources Administration
Department of Social Services

MAP-2161a (E) 05/11/2018

_____ DATE: _____

_____ CASE NAME: _____

_____ CASE NUMBER: _____

HRA HelpLine: 888-692-6116

Dear _____:

An application/recertification for Medicaid has been submitted by or on behalf of the person named above. You have been identified as the Legally Responsible Relative (LRR).

If found eligible, Medicaid will cover that part of the consumer's care for which s/he is unable to pay because of the refusal of the Legally Responsible Relative to make available income and/or resources for the cost of necessary medical care and services.

Legally Responsible Relatives are: a husband for his wife, a wife for her husband, and parents for children under 21.

**IMPORTANT NOTICE: Legally Responsible Relatives may be taken to court for failure to support their spouses or minor children.**

Complete the table below, including your signature and the date, and return this entire form in the enclosed envelope within 10 days.

Name: _____ _____
(First) (Last)

Relationship to the Medicaid Applicant/Recipient (check box): ☐ Spouse ☐ Parent ☐ Other: _____
(specify)

Social Security Number: _____ _____

Name of your Health Insurance Plan (if applicable):
_____

Type of Health Insurance Coverage (i.e. Long-Term Care): _____

Policy Number (if applicable):_____

Contact Number: (_____)_____
Area Code

I declare that I refuse to make my income and/or resources available for the cost of necessary medical care and services for the Medicaid applicant/recipient listed above.

Signature of the Legally Responsible Relative: _____ Date:_____

If you have any questions, contact:

| SUPERVISOR | SECTION | TELEPHONE NUMBER |
|---|---|---|
| | | |

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