

**NOTICE TO FORMER
SSI BENEFICIARY**

NOTICE

DATE: 03/15/2019

CASE
NUMBER:

06102019 N05 MC

[REDACTED]
BROOKLYN, NY 11234-0000



**If you have any questions, call the HRA
InfoLine at 718-557-1399.**

Dear Former SSI Beneficiary:

The Medical Assistance Program has been informed that you are no longer receiving Supplemental Security Income (SSI) benefits. If you wish to continue your Medicaid coverage, please complete and sign the enclosed Recertification Application (Form MAP-3074), submit documentation as asked for, and check the **yes** or **no** box in question #1 on this form. We will then determine if you are still eligible for Medicaid. When you have all of the documents, **make sure you answer every question on the Recertification Application and sign it.**

Mail everything back to us in the enclosed postage-paid envelope, including this notice, within 30 days of the date of this notice. If you have any questions about what you need to document, what is acceptable documentation, or the Community Medicaid Benefit Package described below, **call the HRA Medicaid Helpline at 1-888-692-6116.**

1. Do you have a Home Attendant, Housekeeper, or Homemaker? Yes No
2. Submit proof of the amount of rent you pay and proof of where you live, such as a rent receipt, rent bill on the landlord's letterhead, telephone bill, electric or gas bill, etc.
3. **Resources**
If you have resources such as bank accounts, stocks, bonds, certificates of deposit, etc. and are seeking coverage that includes Nursing Facility services, we will need proof of your resources during the **prior 36 to 60 months**. (Call the HRA Medicaid Helpline at 1-888-692-6116 if you need assistance in determining how many months of documentation to send.) Please send statements from each financial institution in which you have/had resources on account.
 - If you are applying for Community Medicaid Coverage With Community Based Long Term Care (excludes Nursing Facility Services, but includes Waiver Services, Home Care services, Medicaid covered outpatient and inpatient services, doctor, clinic and acute hospital care), you only need to send documentation of your resources in the current month and check this box
 - If you are applying for Community Medicaid Coverage Without Community Based Long Term Care (excludes Nursing Facility Services, Waiver Services and Home Care services, but includes Medicaid covered outpatient and inpatient services, doctor, clinic and acute hospital care), you only need to write in resource information (no documentation required) and check this box
4. If you received any lump sum payments **within the past 12 months**, submit documentation indicating the date you received it, the amount you received, and where you deposited the payment.
5. If you have **life insurance**, send a statement from the insurance company, on their letterhead indicating the face value, net surrender value, name of insured, and policy number.
6. If you are disabled and under 65 years of age, and not in receipt of Social Security disability benefits or Railroad Retirement benefits because of a total permanent disability, you and your doctor must complete and submit to us the enclosed Form DSS-486T, **Medical Report for Determination of Disability**, and Form DSS-1151, **Social Statement for Determination of Disability**. Be sure to read the enclosed Form, **How to Obtain Medicaid in the Aid to the Disabled Category (MAP-252d) and How to Complete Form LDSS-1151 (MAP-252b)**.
7. If you are paying for **health insurance**, send a copy of your identification card, and proof of your last payment, with the period it covers.
8. If your spouse also received this notice, you and your spouse **MUST** mail everything back to us in **one envelope**.

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Human Resources Administration
Department of Social Services

MEDICAID RECERTIFICATION

MAP-3074 (E) 10/16/2013
(Replaces W-296E)

VERIFICATION
(For Agency use only)



| | | | |
|---|-----------|------------|-------------|
| Case Number | Last Name | First Name | Middle Name |
| Do you now receive Public Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No | Street | Apt. No. | |
| Telephone No. | City | State | Zip Code |

A. LIST ALL THOSE WHO REGULARLY LIVE IN YOUR HOUSEHOLD (Including those that are hospitalized, in a nursing home or away at school)

| Name Last First M.I. | On Medicaid | | SSN or Railroad Retirement No. | Relationship | Sex M or F | Birth Date MM/DD/YY | Current Status: Check one: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | Has the person listed become Blind, Disabled or Pregnant? If yes, specify below. |
|-------------------------|-------------|----|--------------------------------|--------------|---------------|------------------------|---|--|
| | Yes | No | | | | | | |
| Self | | | | | | | | |
| Spouse | | | | | | | | |
| Other Household Members | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Is there a parent or husband/wife absent from your household? Yes No If yes, fill out the following:

| Name | | | Relationship | Last Known Address | | | Amount of Contributions, if any |
|------|-------|------|--------------|--------------------|------|-------|---------------------------------|
| Last | First | M.I. | | Street | City | State | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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VERIFICATION
If Not Applicable

D. OTHER INCOME: IS ANY MEMBER OF YOUR HOUSEHOLD RECEIVING ANY OF THE FOLLOWING?

| Source of Income | Yes | No | Name of Person Receiving Income | Date Began MM/EE/YYYY | Amount/Period |
|---|-----|----|---------------------------------|--------------------------|---------------|
| Court-Ordered Payments | | | | | |
| Dividends from Stocks, Bonds, or Life Insurance | | | | | |
| Employer Pension | | | | | |
| GI Allowance | | | | | |
| GI Bill | | | | | |
| Income from Royalties, Schedules, Mortgage, Rental Income | | | | | |
| Income from Relatives or Friends | | | | | |
| NYS Disability | | | | | |
| Other - Describe | | | | | |
| Railroad Retirement | | | | | |
| Social Security | | | | | |
| Union Benefits | | | | | |
| Veterans Benefits | | | | | |
| Workers Compensation | | | | | |

E. RESOURCES: DO ANY OF THE MEMBERS OF THE HOUSEHOLD HAVE ANY OF THE FOLLOWING?

| Resource | Yes | No | Name of Person | Name of Bank | Value |
|---------------------|-----|----|----------------|--------------|-------|
| Account No. 1 | | | | | |
| Account No. 2 | | | | | |
| Account No. 3 | | | | | |
| Bank Account | | | | | |
| Cash on Hand | | | | | |
| Cash/Union | | | | | |
| Pending Lawsuit | | | | | |
| State-Deposited Esc | | | | | |
| Stocks/Bonds | | | | | |
| Trust Fund | | | | | |

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VERIFICATION
For Agency use only

| Resource | | | | | | Dollar Value | |
|--------------------------------|-----|----|----------------|------------|------|--------------|--------|
| Life Insurance Name of Company | Yes | No | Person Insured | Policy No. | Date | \$Cash | \$Face |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

F. OTHER RESOURCES

Does anyone in the household own a House or Land other than the house in which you live or the land on which you live?
 Yes No If yes, fill out the following:

| <input type="checkbox"/> House <input type="checkbox"/> Land | Name of Owner | Value \$ | <input type="checkbox"/> House <input type="checkbox"/> Land | Name of Owner | Value \$ |
|---|---------------|-------------|---|---------------|-------------|
| | | | | | |

Does anyone in the household receive Medicare? Yes No If yes, fill out the following:

| Name of Person | Medicare Card (ID No.) | Part A - <input type="checkbox"/> Yes <input type="checkbox"/> No | Part B - <input type="checkbox"/> Yes <input type="checkbox"/> No |
|----------------|------------------------|---|---|
| | | | |
| | | | |

Does anyone in the household have health insurance coverage? (Check yes if covered by policy of absent parent/spouse)
 Yes No If yes, fill out the following:

| Name of Person | Insurance Company | If Group, Give Name of Employer | Date of Coverage and Period | Premium Amt | Policy Number |
|----------------|-------------------|---------------------------------|-----------------------------|-------------|---------------|
| | | | | | |
| | | | | | |

| APPLICANT | | REPRESENTATIVE | |
|---|--|---|------|
| I hereby certify that I am the applicant named above, and I understand that the information furnished is true and correct to the best of my knowledge and belief and that no facts have been omitted. I understand that I will furnish any additional information which may be required, and I will report immediately any changes in circumstances, including changes in financial resources. I understand that my statements may be investigated and I agree to cooperate in such an investigation. I further understand that the law provides for fine or imprisonment or both for a person hiding facts or not telling the truth. | | I hereby submit this certification for medical assistance on behalf of the applicant named above, and I understand that the information furnished is true and correct to the best of my knowledge and belief. This certification is required with the knowledge that further information may be required. | |
| Signature of Applicant | | Signature of Representative | Date |
| Date | | Address of Representative | |

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TERMS, RIGHTS AND RESPONSIBILITIES
(Renewal)

Human Resources
Administration
Department of
Social Services
MSP-2015a(6) (9/27/2016)

By completing and signing this form, I am applying to renew Medicaid / Managed Long Term Care / Medicare Savings Program (MSP / CMG) and/or Family Planning Benefit Program coverage.

I understand that I must provide the information needed to prove my eligibility for each program. I agree to immediately report any changes to the information on this form. If I am unable to get the information, I will tell the social services district. The social services district may be able to help in getting the information.

I understand that workers from the programs for which family members or I am renewing may check the information given by me on this form. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.

I understand that Medicaid and/or Family Planning Benefit Program coverage will not pay medical expenses that insurance or another person is supposed to pay, and that I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.

I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if it will cause undue harm to my health or safety or to the health and safety of someone I am legally responsible for.

I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.

I understand that if my child is on Medicaid, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program.

I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS I certify under penalty of perjury by signing my name on this form that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. The term "satisfactory immigration status" means an immigration status that does not make the person ineligible for benefits. **Important Information:** The United States Citizenship and Immigration Services (USCIS) has said that enrollment in Medicaid CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member or travel in and out of the country except if Medicaid pays for long term care in a place like a nursing home or psychiatric hospital. The State will not report any information on this application to the USCIS.

SOCIAL SECURITY NUMBER All applicants must provide a social security number or proof that they have applied for one or tried to apply for one. The only exceptions are pregnant women, undocumented immigrants and temporary non-immigrants applying for the treatment of an emergency medical condition, and certain battered immigrants. SSNs are not required for members of an applicant's household who are not applying for benefits unless this person is the spouse and the applicant's eligibility depends on the amount of resources owned by the spouse. Such disclosure is required by Federal Law at 42 U.S.C. 1320b-1(a) and by Medicaid regulations at 42 CFR 435.310. SSNs are used in many ways, both within Department of Social Services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help, and to verify resources with financial institutions for recipients and their non-applying spouse. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient.

RELEASE OF MEDICAL INFORMATION I consent to the release of any medical information about me and any members of my family for whom I can give consent by my Primary Care Provider, any other health care provider or the New York State Department of Health (DOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to DOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is going a Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

MEDICAID MANAGED CARE If I am adding a family member to a Medicaid case and I live in a county that requires Medicaid recipients to join a health plan, I understand that this family member will be enrolled in the same health plan as my family, unless he or she is exempt or excluded.

RELEASE OF EDUCATIONAL RECORDS I give permission to the Local Department of Social Services and New York State to obtain any information regarding the educational records of my children, when needed, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

EARLY INTERVENTION PROGRAM If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local Department of Social Services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

I consent to sharing this information with any school-based health center that provides services to the applicants.