NYC Human Resources Administration
Department of Social Services

MAP-909E…..…….....…Rev. 06/25/09

RENEWAL NOTIFICATION

LOCATION:
NOTICE DATE:
CASE NUMBER:
NUMBER OF ADULTS:
NUMBER OF CHILDREN:
PRIORITY:
RVI CODE:
TELEPHONE NUMBER:

Dear Consumer:

It is time to renew your Medicaid/Managed Long Term Care/Medicare Savings Program (QMB) coverage. Please **carefully read** the printed information that appears below and **write-in** all changes. Be sure to return your entire renewal form, **including this page.**

Use the "**instruction sheet**" that is also enclosed to help you fill out this form. It will help you to understand how to complete the form and to decide what documentation (proofs) to return along with it. You must **complete and sign** this form and attach all required proof.

1. Look at the mailing address and telephone number above. Also look at all information below. If anything is wrong, or has changed since you last applied or renewed your coverage, **write-in the most current** information in the blank space. If the information printed is correct, check the "**No Change**" box.

   If you have recently moved from New York City to another county within New York State, but have not yet had a public health insurance case opened where you now live, you should complete and return this Renewal Form to us

NOTE:

❶ **HOUSEHOLD INFORMATION:** THIS SECTION IS PRE-PRINTED WITH THE NAMES OF HOUSEHOLD MEMBERS WHO ARE RECEIVING MEDICAID ON YOUR CASE. IT ALSO HAS PRE-PRINTED INFORMATION ABOUT THEM. PLEASE UPDATE THE INFORMATION FOR EACH HOUSEHOLD MEMBER IF IT IS WRONG OR IF IT HAS CHANGED. CHECK EACH "NO CHANGE" BOX WHERE THERE IS NO CHANGE. **(PROVIDE PROOF OF ANY CHANGES TO CITIZENSHIP/IMMIGRATION STATUS.)**

	Household Members	Date of Birth	Sex (M/F)	Social Security Number	Citizenship/ Immigration Status	No Change
1						**[ ]**
2						**[ ]**
3						**[ ]**

❷ **ADDRESS WHERE YOU LIVE**: (IF YOU NEED LONG-TERM CARE SERVICES AND IF YOUR ADDRESS HAS CHANGED SINCE YOUR LAST APPLIED/RENEWED YOUR COVERAGE, **PROVIDE PROOF**.)

	No Change **[ ]**
Housing/Rent Payment: How Often?	No Change **[ ]**

❸ **REAL ESTATE:** (**NO PROOF REQUIRED FOR 3A. PROOF REQUIRED IF YOU ANSWERED YES TO 3B.**)

A. Do You Own or Co-Own Your Home? ☐Yes ☐No **If "Yes,"** is your **home equity value** (market value of home or the portion of the home that you own less all mortgages, liens or other debts against the home) more than **$750,000?**

☐ Yes ☐ No

B. Do You Own Real Estate/Real Property other than your primary residence? ☐Yes ☐No **If "Yes"**, provide information requested below:

Address of Property:_____ Value of Property $_____

Income Received from Property: $_____ How Often_____

SECTIONS 4 THROUGH 7 ARE PRE-PRINTED WITH THE INFORMATION THAT WE CURRENTLY HAVE ON FILE FOR YOUR HOUSEHOLD. PLEASE UPDATE THE INFORMATION WHERE IT IS WRONG, MISSING OR IF IT HAS CHANGED. CHECK EACH "NO CHANGE" BOX WHERE THERE IS NO CHANGE.

❹ MEDICARE HEALTH INSURANCE: (NO PROOF REQUIRED)

Premium Amount	No Change
	[ ]
	[ ]

❺ OTHER HEALTH INSURANCE: (PROVIDE PROOF)

Other Health Insurance such as Blue Cross/Blue Shield? ☐Yes ☐No **If "Yes,"** provide name(s) of person(s) and name(s) of insurer below:	Amount of Premium (if known)	How Often (example: weekly, monthly)	No Change
_____	_____	_____	[ ]
_____	_____	_____	[ ]

❻ INCOME: (IF YOU NEED LONG TERM CARE SERVICES OR MAY BE MEDICAID ELIGIBLE WITH A SURPLUS, **PROVIDE PROOF**)

Name	Type of Income	Name of Employer (if income is from employment)	Amount (before taxes and deductions)	How Often (weekly/ bi- weekly/ monthly)	No Change
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]

❼ RESOURCES: (IF YOU NEED LONG TERM CARE SERVICES, **PROVIDE PROOF**. IF YOU ARE RENEWING **MEDICARE SAVINGS PROGRAM (QMB-ONLY)** COVERAGE, YOU MAY **SKIP** THIS SECTION. RESOURCES ARE NO LONGER CONSIDERED WHEN DETERMINING MSP ELIGIBILITY.

NOTE: INCLUDES CASH ON HAND, SAVINGS AND CHECKING ACCOUNTS, CERTIFICATES OF DEPOSIT, STOCK, BONDS, TRUST FUNDS, OWNERSHIP OF A BUSINESS, ETC.

Resource Type(s)	Resource Amount	No Change
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]

If you have a Pooled Trust for which you have made deposits, provide proof of the deposits made from the date you applied for public health insurance or your last renewal (whichever is latest). Provide one of the following:

- An accounting statement or signed letter from the Pooled Trust Administrator confirming receipt of the deposits
- Copy of bank statements showing direct debits or cleared checks to the Pooled Trust
- Copy of cancelled checks to the Pooled Trust

If you have a Pooled Trust for which you have **not** submitted the Joinder Agreement, you must provide a copy of the Joinder Agreement for approval by the Human Resources Administration, Office of Legal Affairs.

❽ **CHILDCARE/DEPENDENT CARE EXPENSES:** (IF YOU NEED LONG TERM CARE SERVICES OR MAY BE MEDICAID ELIGIBLE WITH A SURPLUS**, PROVIDE PROOF**)

CHILDCARE/DEPENDENT CARE EXPENSE AMOUNT	HOW OFTEN

❾ **PREGNANCY AND DISABILITY**: (IF ANYONE IS DISABLED AND YOU NEED LONG-TERM CARE SERVICES OR MAY BE MEDICAID ELIGIBLE WITH A SURPLUS, **PROVIDE PROOF** DISABILITY-RELATED WORK EXPENSES.)

Is anyone in your household pregnant? ☐ Yes ☐ No. **(If yes, provide proof of expected date of delivery. Note: Pregnant women do not need to provide an SSN or proof of immigration status.)**

If anyone on this case blind, handicapped or disabled, do they have to pay special expenses (non-medical) in order to work? ☐ Yes ☐ No

If yes:

WORK-RELATED EXPENSE AMOUNT	HOW OFTEN

Please be sure to answer all of the questions in all of the sections on this form. Remember to sign all of the forms that require a signature and attach all required proofs.

I certify that the answers I have given are true and complete to the best of my knowledge. I have also read and understand the *Terms Rights and Responsibilities.*

Signature of Consumer (or Representative): _____ Date:_____

Signature of Spouse: _____ Date:_____