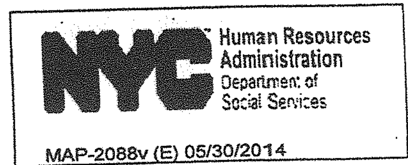
NOTICE OF RENEWAL OF YOUR PUBLIC HEALTH INSURANCE COVERAGE



MAP-2088v (E) 05/30/2014

DATE: 11/19/14

CASE NUMBER:

CIN:

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

Dear Consumer:

The Medical Assistance Program is sending you this notice to tell you that your:

☑ Medicaid ☐ Family Health Plus ☐ Medicare Savings Program ☐ Family Planning Benefit Program

☐ Other ______________________ coverage has been renewed, effective 10-01-14

You continue to remain eligible for the benefits provided by the program checked above.

If checked, the following also applies:

☑ Your monthly surplus (Excess Income) has changed from $ __________ to $ __________

☐ Your monthly surplus (Excess Income) remains $ __________ unchanged.

☐ Your Medicaid coverage, which does not include Long Term Care, will continue. (See enclosed form MAP-2160, **Explanation of the Effect of Transfers of Resources on Medicaid Eligibility**)

☐ You will continue to receive full Medicaid coverage under Medicaid Buy-In For Working People With Disabilities (MBI-WPD).

This decision is based on Section 369-ee of the Social Services Law and Regulation 18 NYCRR 360-4.8

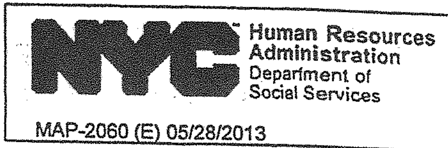
WORKER	TITLE	SECTION

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

Regulations require that you immediately notify this department of any changes in needs, income, resources, living arrangements, or address.

BE SURE TO READ THE ENCLOSED FORM MAP-2086B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION

BUDGET EXPLANATION



CASE NAME ______ **CIN:** ______

We calculated your Medical budget for the period beginning 10-01-14 as follows:

MONTHLY GROSS INCOME	AMOUNT
Employment	$
Interest Income	$
Social Security	$
Child Support	$
Other (specify):	$
Other (specify):	$
Other (specify):	$
TOTAL MONTHLY GROSS INCOME:	$

MONTHLY DEDUCTIONS	AMOUNT
Allowance for disabled, aged or blind persons	$
Work Related Expenses	$
Family Care Expenses	$
Health Care Expenses	$
Child Support Exemption	$
Other (specify):	$
TOTAL MONTHLY DEDUCTIONS:	$
TOTAL MONTHLY NET INCOME (gross income minus deductions)	$

MONTHLY ALLOWANCES	AMOUNT
The monthly Medicaid allowance for your household is:	$
The monthly Medicare Savings Program allowance for your household is:	$
The monthly Family Health Plus allowance for your household is:	$
The monthly Family Planning Benefit Program allowance for your household is:	$
The monthly Public Assistance Standard of Need for your household is:	$

After subtracting the appropriate monthly allowance from your monthly net income, we have determined that your income exceeds this allowance by: $

(See back of page for resource details, if applicable)

RESOURCES (exempt resources such as money held in a burial fund are not shown below)	AMOUNT
Bank Accounts:	$
Other (specify):	$
Other (specify):	$
Other (specify):	$
TOTAL RESOURCES:	$

RESOURCE ALLOWANCE	AMOUNT
Medicaid Resource Allowance	$
Public Assistance Resource Allowance	$

After subtracting the appropriate resource allowance from your non-exempt resources, we have determined that your resources exceed this allowance by: $________

	WORKER (Sign)	SECTION
SUPERVISOR (Print)		DATE

MEDICARE SAVINGS PROGRAM (MSP)

Social Services

MAP-258k (E) 04/02/2013
Replaces MAP 2158K, MAP-2087U

NOTICE DATE: 11/19/14

CASE NAME:

CASE NUMBER:

If you have any questions, call the HRA Infoline at 718-557-1399

Dear Consumer:

- ☐ We have received the Medicare Savings Program (MSP) application that you submitted.
- ☐ We have been notified by the Social Security Administration that you may be eligible for the Medicare Savings Program (MSP). They have submitted an electronic application to us on your behalf.
- ☐ We have reviewed your request to join the Medicare Savings Program (MSP) and determined that you are currently receiving Medicaid.
- ☐ We have received your inquiry.

fold

This notice concerns your **eligibility** under the **Medicare Savings Program (MSP)**. If you are currently receiving Medicaid and it is determined that you are eligible for MSP, this may affect your Medicaid.

fold

Effective 10-01-14, we will take the action(s) indicated below for the following persons:

APPLICATION

The Medical Assistance Program will: (Check all boxes that apply).

☐ **ACCEPT** your application for **MSP** as indicated below:

- ☐ **SLIMB**: Eligible for payment of your **Medicare Part B** premium
- ☐ **QI-1:** You meet the requirement for full payment of your **Medicare Part B** premium
- ☐ **QMB**: Eligible for payment of your **Medicare** Co-Insurance, Deductible and **Part B** premium

The amount of the payment will be determined by the Social Security Administration and will be included in your benefit check or credit or direct deposit within 4-6 months from the date of this notice. This is the only notice you will receive from the Medical Assistance Program.

☐ **TAKE NO ACTION** on the **MSP** application dated ______________ since it was **withdrawn.**

☐ **DENY** your MSP for the application dated ______________ because:

- ☐ The allowable income level is $__________ per month and your income exceeds this allowance by $__________. See the enclosed MAP-2060, **Budget Explanation** to see how we calculated you income.
- ☐ Other: ______________________________

BE SURE TO READ THE ENCLOSED FORM MAP-[illegible] FOR YOUR RIGHTS [illegible] TO APPEAL THIS DECISION

RENEWAL (Undercare)

The Medical Assistance Program will: (Check all boxes that apply).

☐ **ENROLL** you in the **MSP** as indicated below:

- ☐ **SLIMB**: Eligible for payment of your **Medicare Part B** premium
- ☐ **QI-1:** You meet the requirement for full payment of your **Medicare Part B** premium
- ☐ **QMB**: Eligible for payment of your **Medicare** Co-Insurance, Deductible and **Part B** Premium

☐ **CONTINUE** your benefits for: ☐ SLIMB ☐ QI-1 ☐ QMB

☐ **CHANGE your MSP benefits from:** ☐ QMB ☐ SLIMB ☐ QI-1 to: ☐ QMB ☐ SLIMB ☐ QI-1

☒ **DISCONTINUE** your ☒ SLIMB ☐ QI-1 ☐ QMB benefits because:

- ☐ The allowable income level is __________ per month and your income exceeds this allowance by $__________.
- ☐ Determined that you are eligible for Medicaid with a Surplus and are eligible for MSP. Your surplus is $__________. (See enclosed MAP-258d and MAP-2060)
- ☐ You were enrolled in MSP in error. You are/remain eligible for Third Party premium payments.
- ☐ You remain eligible for Medicaid with a Surplus and eligible for MSP, however your surplus has changed from $__________ o $ __________. (See enclosed MAP-258d and MAP-2060)
- ☐ Other: ______________________________

NOTE: You/members of your family may be eligible for other public health insurance coverage such as the Medicaid Excess Income Program, whether or not you remain eligible for QI-1 benefits. However, you may not have Medicaid Spenddown coverage at the same time that you are receiving QI-1 benefits. **If your coverage was renewed for QI-1, you may now be eligible for MSP at either the SLIMB or QMB level. See the enclosed MAP-931**, Explanation of [illegible] Program, **MAP-931R**, Explanation of Resource Documentation [illegible]