NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION/RECERTIFICATION

(Home Care Services/Managed Long Term Care)

NYC Human Resources Administration
Department of Social Services

MAP-259p (E) 10/16/2012

[redacted]

DATE: 11/19/14

CASE NUMBER: [redacted]

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

CHECK PROGRAM AREA

- ☐ Home Care Services Program
- ☒ Managed Long Term Care Program

Dear Consumer:

We are sending you this notice to tell you that the Medical Assistance Program will:

☒ **ACCEPT** your Medicaid application/recertification for **full** Medicaid coverage from: 1/1/15

For the following person(s): [redacted]

☐ **ACCEPT** your Medicaid application/recertification with a **spenddown** (excess/ surplus income) from: _____

For the following person(s): _____

We have certified that you have a continuing need for Home Care/Managed Long Term Care Services.

WE HAVE DETERMINED YOUR SPENDDOWN AS FOLLOWS:

A. Total monthly income	$
B. Total monthly deductions	$
C. Net Medicaid income (line A minus line B)	$
D. Medicaid level for your household size	$
E. Monthly Excess Income (line C minus line D)	$

THIS IS NOT A BILL. DO NOT SEND ANY MONEY TO MEDICAID. YOU WILL RECEIVE A BILL SHORTLY. FOLLOW INSTRUCTIONS ON THE BILL.

You are required to pay your full excess (surplus) income or spenddown in the amount of $[redacted] each month to the agency providing your Home Care/Managed Long Term Care services. You will receive your first bill shortly. This bill will be retroactive to the date indicated above and may be for more than one month's service.

This decision is based on Social Services Law or Regulation: [redacted]

WORKER [redacted]	TITLE [redacted]	SECTION [redacted]

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

[redacted]

NOTICE CONCERNING ELIGIBILITY FOR THE MEDICARE SAVINGS PROGRAM (MSP)

NYC Human Resources Administration Department of Social Services

MAP-258d (E) 05/17/2011
(Replaces MAP-2158D)

[redacted]

NOTICE DATE: 11/19/14

APPLICANT'S NAME: [redacted]

CASE NUMBER: [redacted]

Dear Consumer:

fold fold

This is to advise you that the Medical Assistance Program (MAP) has determined that:

☒ You are/remain eligible for full Medicaid benefits if you pay/continue to pay your Medicare Part B Premium. However, if you wish to join the **Medicare Savings Program** (MSP) and have your Medicare premium and other coinsurance payments paid, you will only be eligible for Medicaid with **excess income** and can receive Medicaid coverage in any month when paid or unpaid medical bills equal to or exceed your monthly **excess income** amount of $[redacted]. You will have to prove that you have medical expenses each month at least equal to this amount before you can get Medicaid coverage for the rest of the month's medical bills.

☐ You are already enrolled in the **Excess Income Program.** If you now wish to have MAP pay your Medicare premium and other coinsurance payments, your Medicaid monthly **excess** will increase from $ _____ to $ _____. You will have to prove that you have medical expenses each month equal to this new higher amount each month before you can get Medicaid coverage for the rest of the month's medical bills.

☐ You are already enrolled in the **Medicare Savings Program (MSP)** and are receiving benefits at the QMB/SLIMB level. You are now also eligible for Medicaid, under the **Excess Income Program**, with a monthly excess of $_____. You will have to prove that you have medical expenses each month at least equal to this amount before you can get Medicaid coverage for the rest of the month's medical bills.

☐ You are already enrolled in the **Excess Income Program**. Because your income/income eligibility level has recently changed, if you choose to join/remain in the in the **Excess Income Program**, your monthly excess will change from $_____ to $_____ and your MSP coverage which is currently at the _____ level will be converted to _____ level coverage.

You will have to prove that you have medical expenses each month at least equal to this new amount before you can get Medicaid coverage for the rest of the month's medical bills.

☐ You are not eligible for both Medicaid and MSP (QI-1). You can only choose one. If you choose not to join the Medicare Savings Program, we will process your application for the **Excess Income** and/or the **Excess Resource Program**.

NOTE: For most people, full Medicaid coverage is more beneficial. For some people who receive a lot of Medicare-covered services which are not covered by Medicaid, such as chiropractic services, not having to pay the Medicare Part B Premium and being eligible for Medicaid with excess income might be advantageous.

If you are currently receiving Food Stamps and you choose to join the MSP, your Food Stamp benefits may be reduced.

See the enclosed form MAP-931, **Explanation of the Excess Income Program.** If you are currently enrolled in MSP, also see the enclosed MAP-258E, **Client Request to Opt Out/ Be Removed From the MSP**. You will need to sign and return this form **if you wish to be disenrolled from MSP**.

Please tell us how we should proceed by checking the box in the bottom section of this form that describes your choice. Then print your name, sign and date the form and return it, by mail, within 30 days of the date of this notice, to the address provided below:

☐ **Medical Assistance Program (MAP)**
CREP MSP Coordinator
330 West 34th Street 11th Fl
New York, NY 10001

☐ **HRA/ MICSA**
Nursing Home Eligibility Div
P.O. Box 2749
New York, NY 10116-2749

☒ **Medical Assistance Program (MAP)**
Eligibility Division
MICSA Home Care Services Program
Centralized Medicaid Eligibility Unit
785 Atlantic Avenue - 7th Floor

☐ **MAP/OMR**
(Note: Please return this form with your deferral letter)

[redacted]

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