MAIL RENEWAL PROGRAM
HRA/MEDICAL ASSISTANCE PROGRAM
PO BOX 329060
BROOKLYN, NY 11232-9823

Address Service Requested

[redacted]

NYC Human Resources Administration
Department of Social Services

MAP-909e (E) 01/04/2022

RENEWAL NOTIFICATION

Medicaid/Medicare Savings Program (QMB)

LOCATION: CED/Surplus
NOTICE DATE: 05/06/2023
CASE NUMBER: [redacted]
NUMBER OF ADULTS: 01
NUMBER OF CHILDREN: 00
PRIORITY: N
RVI CODE: 2
TELEPHONE NUMBER: [redacted]

Dear Consumer:

It is time to renew your Medicaid/Managed Long-Term Care Medicare Savings Program (MSP/QMB). Renewal instructions are attached to help you. **Complete and sign** this form and include all required proofs (explained more below). Return your entire renewal form in the enclosed envelope, **including this page.**

You must return the completed form and proofs **before** 07/10/2023 or your coverage may end. If your coverage ends, depending on the coverage that you have now, we will no longer provide you with health insurance coverage or pay your Medicare premium, deductible or co-pays.

Review the form carefully. If anything is wrong or has changed, you must write in the correct information. If it is correct, check the "**No Change**" box.

If you moved from New York City to another county within New York State, but a new case has not yet been opened where you now live, you should complete this form and we will make sure your renewal gets to your new local district.

Required Proofs

You **must provide** certain "proofs" supporting the information you provide on this form, such as:

- Proof of any change in your immigration status, if you are reporting a new status;
- Proof of any change in your health insurance other than Medicare, including any change to the premium that you pay;
- If you are blind or have a disability, proof of disability-related work (non-medical) expenses, if any, and;
- If you are enrolled in the Medicaid Buy-In Program for Working People with Disabilities;
  - Proof of current employment; **or**
  - A letter stating that you lost your job within the last six months either because of a change in medical condition or through no fault of your own (for example, you were laid off).

Required Proofs – Pooled Trust

If you have a Pooled Trust in which you have made deposits, provide proof of all deposits made since the date you applied for Medicaid or your last renewal (whichever is most recent). For proof of these deposits, you must 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 a Joinder agreement, you must provide a copy of the Joinder Agreement for approval by the Human Resources Administration, Office of Legal Affairs.

If you are married and your spouse is not on Medicaid, we may need to check if there are resources held in your spouse's name that are not in your name. Complete the "Authorization for Verification of Resources (Legal Spouse)" form included in this packet unless you are only applying to renew Medicare Savings Program (MSP) . This form is required to determine your eligibility.

If you or your representative needs help filling out the form or getting the documents, call the Medicaid helpline at 1-888-692-6116. You can also complete and submit Reasonable Accommodation Request form. A copy of this form has been included in this mailing.

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 888-692-6116. 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.

Human Resources Administration
Department of Social Services

MAP-3185 (E) 01/19/2023

Act Now! - Medicaid Renewal Rules Have Changed

To renew your Medicaid coverage, you **must complete and submit your renewal form by the date listed on your form. You may lose your Medicaid coverage if you do not return your renewal form by the date requested.**

Directions for completing your Medicaid renewal:

1. Read your renewal form and attached directions carefully;
2. Complete the Form, making any changes to your household members, the amount of your rent, your insurance premiums, your income, your resources, and other any other categories on the form;
3. Include any documents or "proofs" requested on the form; and
4. Return it to the address on the renewal form.

You may call your local department of social services at 888-692-6116 for help with this form.

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 888-692-6116. 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.

[redacted]

[redacted]

1. **HOUSEHOLD INFORMATION:** This section is printed with the names of family members on your case.

- Household Members," "Date of Birth," and "Sex" columns:
  - ➢ Update the information if it is wrong or if it has changed.
  - ➢ If there is no change in household, check the "No Change" box.
- "Social Security Number" column:
  - ➢ If **"ADD SSN"** is printed in the "Social Security Number" column, write in your/your household member's Social Security Number.
  - ➢ If "**NUMBER ON FILE**" is printed in the "Social Security Number" column, we already have the SSN.
- "Citizenship/Immigration Status" column:
  - ➢ If "Send Proof" is printed in the "Citizenship/Immigration Status" column, or your immigration status has changed, send the most recent letter received from the federal immigration agency or other proof of current immigration status.
  - ➢ If you are declaring that you are a U.S. citizen, place a **"C"** in the "Citizenship/Immigration Status" column.
  - ➢ You do not need to send proof of citizenship at this time. If proof is needed, you will receive a letter requesting it.

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

2. **ADDRESS (No Proof Required)**

Residential Address [redacted]	No Change [ ]
Secondary Address for Notices (if provided) [redacted]	No Change [ ]
Associated Address for Notices (if provided)	No Change [ ]
Housing/Rent Payment [redacted] How Often? Monthly	

3. **MEDICARE HEALTH INSURANCE**: No Proof Required for Medicare Part A or Part B. However, proof of your Part C (Medicare Advantage Plan) premium, if any, is required. This may be used to reduce your Medicaid income.

Premium Amount	No Change
	[ ]
	[ ]

4. **OTHER HEALTH INSURANCE: You need to answer this question, even if the answer is "no." If the answer is "yes,"** you should provide proof of payment for any health insurance premium cost other than Medicare Part A or Part B. This may be used to reduce your Medicaid income.

Other Health Insurance ☐Yes ☐No **If Yes**, write-in name of insurance company. below: _____ _____	Amount of Premium [redacted] _____	How Often (example: weekly, monthly) _____ _____	No Change [ ] [ ]

5. **Income**: If you need to upgrade your coverage to include Community-Based Long Term Care Services (for example Managed Long Term Care), or if you expect to be eligible for Medicaid with a surplus, provide proof of income.

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
	Social Security Retirement		[redacted]	Monthly	[ ]
	Retirement		[redacted]	Monthly	[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]

6. **RESOURCES**: No Proof Required Unless Indicated Below.
Resources include cash on hand, savings and checking accounts, certificates of deposit ("CDs"), stocks, bonds, trust funds, 401Ks, mutual funds, ownership of a business, property that you or someone in your family owns, etc. **Do not list the home that you live in.**

Complete the tables below and the Authorization for Verification of Resources (Applicant) form included in this packet. This form is required to determine your eligibility.

If you do not have any resources, please write "NONE" under "Resource Type(s) in the table below. If your resources have changed from what is printed below, please update the list.

Resource Type(s)	Resource Amount	No Change
Bank Accounts	[redacted]	[ ]
Bank Accounts	[redacted]	[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]

You do not need to send proof of bank accounts at this time. However, if the computer match shows something different than what you reported, you may be asked to provide proof at a later date.

A. Do you own real estate/real property other than your primary residence?
☐ Yes ☐ No

If Yes, provide the information requested below:

Address of Property: _____

Value of Property: _____

Income Received from Property: $ _____ How Often: _____

Do you own or co-own your home? ☐ Yes ☐ No **If Yes**, is your **home equity value** (the market value of the home or the portion of the home that you own, less all mortgages, liens and other debts against the home) more than $ 1,033,000 **?** ☐ Yes ☐ No

AUTHORIZATION TO VERIFY RESOURCES
YOU MAY SKIP THIS SECTION IF YOU ARE RENEWING MEDICARE SAVINGS PROGRAM COVERAGE ONLY

If my eligibility to renew coverage depends on the amount of my and my spouse's resources (even if my spouse is not receiving/ renewing Medicaid coverage), by signing below we authorize verification of our resources with financial institutions to determine eligibility. **Both spouses must sign below.**

This authorization will end:

- If my application for Medicaid is denied,
- If I am no longer eligible for Medicaid
- If I/we revoke this authorization in a written statement to my local Department of Social Services.

I understand that I will not be asked to prove resources that can be verified electronically, but that I can be asked to prove resources when electronic verification cannot be used.

Fill in the information for a **spouse** who is not applying for/receiving Medicaid:

Last Name	First Name	Middle Initial

Maiden Name or Other Name Known By	Social Security Number	Date of Birth

Address only needed if the address is different from that of the renewing spouse.)

House Number	Street	Apartment Number

City	State	Zip Code

7. POOLED TRUST DEPOSITS (Provide Proof of Deposits)

Pooled Trust Deposit Amount	How Often

8. CHILDCARE/DEPEDENT CARE EXPENSES (No Proof Required)

Childcare/Dependent Care Expense Amount	How Often

9. **PREGNANCY AND DISABILITY**: Provide proof of disability-related work expenses in order to reduce your Medicaid income. No proof related to a pregnancy for any family member is required.

Is anyone on your Medicaid case pregnant? ☐ Yes ☐ No

If Yes, who is pregnant?

If Yes, what is the expected date of delivery? _____

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

If Yes:

Work Related Expense	How Often

10. **Vision Disability:** (No Proof Required)

We are working to provide our notices to you in the below formats. If you would like notices to be sent to you in one of these formats as they become available, just check one of the boxes below. You can also call us at 1-888-692-6116 for assistance with reading notices that you cannot read.

☐ Large Print
☐ Audio CD
☐ Data CD
☐ Braille

11. **Language Preference**

The language that I speak is: _____

The language that I read is: _____

Please be sure that you answered all the questions on this form, in all the sections. **Remember to sign Page 8.**

Mail this completed form and all required documentation in the enclosed postage paid envelope **before** the "respond before" date printed on Page 1.

I certify under penalty of perjury that everything on this application is the truth, as best I know. This includes the Financial Maintenance at Renewal information that I may have chosen to provide at this time by completing Page 9 of this Renewal Notification. I have also read and understand the Terms, Rights and Responsibilities.

I understand that this information is used to determine continuing eligibility for public health insurance programs. I also understand that if I intentionally misrepresent my situation, I may have to repay the cost of benefits received and may be subjected to prosecution to the fullest extent of State and Federal law.

SIGN HERE ☞

Signature of Consumer /Representative:

_____ Date: _____

Signature of Legally Responsible Relative/Spouse or Representative (if applicable):

_____ Date: _____

If you are married, both you and your spouse must sign.

Navigators and other third-party external organizations (if assisting the consumer) must read the following and sign below.

By having signed this Renewal Notification, I certify that the information reported on this form was provided solely by the applicant/recipient. This includes the Financial Maintenance at Renewal information that the applicant/recipient may have chosen to provide at this time by completing Page 9 of this Renewal Notification. I did not modify the information in any way. I understand that if I intentionally falsified information on this form or if I assisted the applicant/recipient in falsifying any information, I may lose my job and be prosecuted to the fullest extent of State or Federal law.

FOR EXTERNAL ORGANIZATION USE ONLY: To be completed by the organization, if any, assisting with this Renewal Form.

Employer's Name: _____

Worker's Name (print): _____

Worker's Signature: _____

Date Signed: _____

Financial Maintenance at Renewal

Important Notice: You must fill out this form only if your share of monthly housing expenses is more than 70% of your gross monthly income. Most consumers are **not required** to complete this form.

For example: If your gross, total income (before any deductions) is $1,000 per month and your rent/mortgage is $500 per month, then you are only spending 50% ($500 of $1000) of your monthly income on housing, and you **do not need to** complete this form. But, if your gross income is $1,000 per month and your rent/mortgage is $800 per month, you are spending 80% ($800 of $1000) of your monthly income on housing, and **you must** complete this form.

If you know that this form applies to you, please complete and sign it now. If you are unsure whether this form applies to you, you can choose to either complete the form now or leave it blank. If you leave it blank and we determine that it is required from you, we will send you another form. We will suspend our processing of your case for up to 14 days while we await your response. If we **do not** receive your response within those 14 days, we will not be able to renew your coverage and your case will be **closed.**

Monthly Living Expenses	Explanation of Expenses
If you have any of the following monthly living expenses, please check (☑) the box and write in the monthly amount spent on each item.	Explain how you pay for each of your monthly living expenses (such as cash on hand, checking/savings account monies, income/wages, credit cards, help from others). List the name and relationship to you of anyone providing help. If the expense has not been paid, please make a note of this and indicate how long it has not been paid.

☐	Rent/Mortgage/ Property Taxes	$	
☐	Water	$	
☐	Childcare	$	
☐	Cable	$	
☐	Phone	$	
☐	Heat	$	
☐	Electricity	$	
☐	Food	$	
☐	Transportation	$	
☐	Credit Card Payments	$	
☐	Other	$	
Total Monthly Living Expenses $ _____ Total Gross Monthly Income $ _____			

Authorization for Verification of Resources (Applicant)

NYC Human Resources Administration Department of Social Services

MAP-3179 (E) (DOH-5148) 09/09/2021

This form authorizes Medicaid to request records from financial institutions for an individual applying for Medicaid.

This Authorization must be signed by the applicant if the applicant is:

- Age 65 or older
- Certified blind or certified disabled (of any age)

Please provide the information for the applicant below and sign the authorization. Signing this Authorization is a condition of receiving Medicaid benefits. This is because eligibility depends on the amount of resources owned by the applicant.

Failure to sign and submit this Authorization may result in a denial or discontinuance of Medicaid benefits.

I. INFORMATION FOR APPLICANT

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth	

II. AUTHORIZATION

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid.

This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I revoke this authorization in a written statement to my local Department of Social Services.

Signature of Applicant /Legal Representative* _____

Date Signed _____

*Note: If a legal representative is signing this authorization, also include the legal document giving their authority to act on behalf of the applicant.

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 888-692-6116. 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.

Authorization for Verification of Resources (Legal Spouse)

NYC Human Resources Administration
Department of Social Services

MAP-3179a (E) (DOH-5149) 09/09/2021

This form authorizes Medicaid to request records from financial institutions for the **spouse** of an individual applying for Medicaid.

This Authorization must be signed by the applicant's spouse if the applicant is:

- Age 65 or older
- Certified blind or certified disabled (of any age)

Please complete all sections and sign the authorization.

Signing this Authorization is a condition of receiving Medicaid benefits. This is because eligibility depends on the amount of resources owned by the applicant and the applicant's spouse.

Failure to sign and submit this Authorization may result in a denial or discontinuance of Medicaid benefits.

I. INFORMATION FOR APPLICANT

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth

II. INFORMATION FOR APPLICANT'S SPOUSE

Last Name	First Name	Middle Initial
Maiden Name or other Name Known By	Social Security Number	Date of Birth

Address is only needed if the address is different from that of the renewing spouse.

House Number	Street Name	Apt Number
City	State	Zip Code

III. AUTHORIZATION

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid for my spouse.

This authorization will end if my spouse's application for Medicaid is denied, or my spouse is no longer eligible for Medicaid or, I revoke this authorization in a written statement to my local Department of Social Services.

Signature of Applicant's Spouse/Legal Representative* _____

Date Signed _____

***Note:** If a legal representative is signing this authorization, also include the legal document giving their authority to act on behalf of the spouse.

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 888-692-6116. 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.

RENEWAL INSTRUCTIONS

Human Resources Administration
Department of Social Services

MAP-2096p (E) 09/09/2021

Step 1 Answer all questions on the Renewal form (MAP-909e). If the instructions tell you that you must provide proof, see the bottom and the back of this page for a list of what you can use as proof.

Step 2 The **Financial Maintenance at Renewal Form,** on Page 8 of the **Renewal Notification** form (MAP-909e), is only needed if your share of monthly housing expenses is more than 70% of your gross monthly income.

Step 3 If you are enrolled in a Managed Long-Term Care Plan, contact them if you need help to complete your Renewal form.

Step 4 If you have a spouse that is not applying for Medicaid, complete and sign the MAP-3179a (E) Authorization for Verification of Resources (Legal Spouse).

Step 5 Return your completed **Renewal** form, the MAP-3179a E) Authorization for Verification of Resources (Legal Spouse) and proofs to us using the enclosed postage-paid envelope. Please respond before the date printed on Page 1 of the Renewal form (MAP-909e).

Reminder: If you are married, **you and your spouse must** sign Page 7 of the Renewal Notification.

Step 6 If you do not have our envelope, mail the package to:

MAIL RENEWAL PROGRAM
HRA/MEDICAL ASSISTANCE PROGRAM
PO BOX 329060
BROOKLYN, NY 11232-9823

REMEMBER - If you do not follow these instructions, your Medicaid coverage may end.

If you mail your documents to us before the date noted on your Renewal form, your current benefits may continue **unchanged** until further notice.

NOTE:

- You do not need to send proof of income and resources unless the renewal form tells you to do so. The amount of income that you report will be compared to available computer matches. If the results of the computer matches are different than the information you give us, the computer match results will be used when deciding your eligibility. You may send proof of your income and resources to make sure we have the right information. If you choose not to send it now, you may be asked to show proof of your income and/or resources later on. The table on the back of this page shows you what can be used as proof.
- If you just moved from New York City to another county in New York State, but do not have a Medicaid case opened where you live now, you should complete and return the Renewal form (MAP-909e) to us. We will help you in moving your coverage.

INCOME AND RESOURCE DOCUMENTS: All income and resource documents must be current. Do **not** send original documents - only copies.

INCOME: Common types of income and good proofs of that income include the following:

Type of Income	Documentation		Type of Income	Documentation
Earned Income from Employer	Current paycheck/stubs ([4] four consecutive weeks) or letter from employer		Worker's Compensation	Award letter or check stub
Self-Employment Income	Current signed income tax return and all schedules or record of earnings and expenses		Veteran's Benefits	Award letter, benefit check stub, or correspondence from Veterans Administration
Rental/Roomer-Boarder Income	Letter from roomer, boarder, tenant or check stub		Military Pay	Award letter or check stub
Employment Based Sick Pay/Disability Income	Award letter/certificate, benefit check stub, or correspondence from source of income		Interest/Dividends/Royalties	Current statement from bank, credit union, or financial institution, letter from broker, letter from agent, or 1099 or tax return (if no other documentation is available)
Unemployment Benefits	Award letter/certificate, monthly benefit statement, correspondence from the NYS Department of Labor, printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us), or copy of Direct Payment Card with printout		Support from other Family Members	Signed statement or letter from family member
Private Pensions/Annuities	Statement from pension/annuity		Income from a Trust	Trust document
Social Security	Award letter/certificate, annual benefit statement, or correspondence from Social Security Administration		Child Support/Alimony	Letter from person providing support, letter from court, child support/alimony check stub, copy of NY Eppicard with printout, copy of child support account information from www.newyorkchildsupport.com, or copy of bank statement showing direct deposit

EMPLOYMENT: If you are enrolled in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD), you need to show proof of your employment. You can send us one of the following:

Detailed written statement from employer		W-2 form
Current paycheck/stub		Income tax return

RESOURCES: Resources include cash on hand, savings and checking accounts, certificates of deposit, stocks, bonds, trust funds, 401Ks, mutual funds, ownership of a business, property that you or someone in your family owns, etc.

Acceptable proof of resources include:

Statements/accountings from the financial institutions in which they are held		Real estate appraisals/assessment
Copies of policies/certificates		Promissory note copies

MEDICARE PART C (Medicare Advantage Plan) / Private Heath Insurance: If you receive your Medicare coverage through a Medicare Advantage Plan, you may be entitled to have the cost of your policy premiums deducted from the income that we budget to determine your eligibility/ongoing eligibility. Since plan premiums differ, you must supply proof of your cost.

This income deduction may also apply to you if you pay a health insurance premium to your employer, your union or a third-party insurer.

You can send us one of the following:

Paid invoice		Cancelled check or money order
Copy of bank statement showing payment		Correspondence from insurance provider acknowledging receipt (and dollar amount) of premium payment made
Paystub showing payroll deduction for the cost/your share of the cost for your health		

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 888-692-6116. 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.

HEARING IMPAIRED CONSUMERS WITH TEXT TELEPHONE (TTY) DEVICES MAY CONTACT US AT 718-636-7783 OR BY CALLING 711