NYLAG
New York Legal Assistance Group

TIPS FOR MEDICAID RENEWALS/RECERTIFICATIONS IN NEW YORK CITY

This fact sheet is for people whose Medicaid is administered by the NYC Medicaid program, run by the Human Resources Administration (HRA). If your Medicaid is handled by the New York State of Health – your renewal is not covered in this fact sheet.

Medicaid is authorized for one year at a time. Approximately 3 – 4 months before the end of your "authorization period," you should receive a renewal packet by mail, which includes instructions on how to complete and return it to HRA. This process is also called "recertification." Here are tips for handling renewals, including how to obtain a copy of the renewal form if you don't receive one in the mail.

1. **Keep track of your Medicaid authorization period so you know when to expect your Medicaid renewal.**

    a. You can find the starting month of your authorization period on your Medicaid acceptance letter. The starting month listed in the acceptance letter will be EARLIER than the date of the notice at the top of the acceptance letter. The ***attached sample*** *Notice of Decision on Your Medical Assistance* is dated July 31, 2019, and the starting month of the Medicaid authorization is July 1, 2019 (attached as Page 6 of this fact sheet). The renewal in that case would be sent between January – March 2019.

    b. If you are enrolled in an MLTC plan, your MLTC plan will probably notify you of an upcoming renewal shortly before HRA mails you the renewal packet.

2. **If you receive your renewal packet in the mail**, don't throw out the enclosed **gray return envelope**. As explained below, you will send back the completed renewal packet in the gray envelope.

3. **Obtain your renewal packet if you don't receive it in the mail**:

    a. Set up an account on the **ACCESS HRA Website** following this link - https://a069-access.nyc.gov/accesshra/. To set up an account, you will need to create a username, password, and select a security question. You DO NOT need an email address to set up an account. Once you create an account and log in, you may be asked to enter your date of birth and Social Security Number or CIN. Please enter this information to locate your case in HRA's system. You will then be able to download and print your individualized renewal form. Use this personalized renewal form instead of a new Application, as your renewal packet has a unique barcode and other information that is specific to your case.

    b. If you are unable to use the Access HRA website, request a copy of your renewal packet by calling HRA's automated line at **1-888-692-6116.**

c. **If you recently moved** and have not updated your address with HRA, you will not receive your renewal, as it will be mailed to your last known address.

- If you won't be receiving your renewal for at least 4 months, report your new address to HRA immediately. Call the Medicaid helpline at 1-888-692-6116 to update your address or complete and fax the MAP-751K form* to 1-917-639-0837 (download at https://www1.nyc.gov/assets/hra/downloads/pdf/services/health/MAP-751K.pdf). Please make sure to keep fax confirmation. *The MAP-751K is also posted in languages other than English in this link. (Updated 2-18-2021)
- If your renewal period is coming up in the next 4 months, use Access HRA to download a copy of the renewal form (see No. 3a above).

4. **How to fill out the renewal packet** (See a sample of the renewal form at http://www.wnylc.com/health/download/628/)

a. **WRITE in big, clear letters on top of the form** and in any white space if you get any special type of Medicaid budgeting -- such as "Spousal Impoverishment," "Spousal Refusal," "MBI-WPD," "Pooled Trust," "MAGI-like," or "Special MLTC Housing Standard." Also write in if you want the Medicare Savings Program as well as Medicaid. For info about the special Medicaid budgeting rules, see http://www.wnylc.com/health/entry/222/.

b. **Include all household members** and their information. This includes your spouse if your spouse lives with you, and any minor dependent children (or grandchildren or other relatives) under age 18 or under 19 if in school who live with you. *Do not list* your adult children, your siblings, or other roommates.

c. **Make any changes**, if applicable, to the amount of your rent, your insurance premiums, your income, and your resources.

d. If you have a **Pooled Income Trust**, be sure to check the box saying you are enclosing Verification of Deposits and obtain this document from your Pooled Trust organization reflecting all deposits you have made for the last year. Many Pooled Trusts now make this document available online for download.

e. If your share of household expenses for rent and utilities are more than 70% of your monthly gross income, fill out the Financial Maintenance Form that explains how you meet your expenses. If someone pays one or more of your bills, write "paid for by _____." You may want to include a letter from this person stating that they pay this bill on your behalf.

ALERT: If family or friends help you financially, they should never give you cash. Cash counts as income and increases your spend-down. They may instead pay bills on your behalf, such as rent, utilities, cell phone, etc. They must pay the bills directly to the landlord, utility company, etc.

5. **What to include** with your renewal packet:

    a. If you have a **Pooled Income Trust**, include a current ***Verification of Deposits*** for the last year through the current month. Ask your Trust Organization for this form. Many Pooled Trusts now make this document available online for download.

    b. Proof of payment of **health insurance premiums**. (Ex: Medigap, dental, vision, union/retirement, etc.). Note: this proof may appear in your pay stub.

    c. Proof of **income for all of your household members**, including: pension letter, letter from employer, paystubs, etc. You do not have to include a letter showing your current Social Security amount, but it is a good idea to include anyway.

    d. If you have an **I.R.A.,** include the most recent statement that shows the amount of your Required Minimum Distribution (RMD) for the current year. Include proof that you are taking or that you have requested regular periodic distributions.

        - ***2020 Alert*** - Even though no one is required by the IRS to take RMD's in 2020 because of COVID, Medicaid still requires it, unless you are under age 65, disabled, and working.

        - Even if you are under age 70½ (or under 72 if you turned 70 on July 1, 2019 or later) and you are not required by the IRS to take distributions, Medicaid still requires that you take periodic distributions, unless you are under age 65, disabled, and working.

    e. Proof of **resources** -- current bank and investment account statements that **you or your spouse own**, even if you own them jointly with someone else. Include a statement of your burial fund account if you have one.

    f. If applicable, a copy of the signed **Spousal Refusal form**, if any, even if you submitted it before (download at http://www.wnylc.com/health/download/66/).

    g. If you are in an MLTC plan and have the **Special Income Standard for Housing Expenses** because you were in a nursing home or adult home in the past, you need to complete, sign and include this form. http://www.wnylc.com/health/download/398/

    h. ***BEST PRACTICE TIP***: Write clearly on top of the renewal form and, if you wish, in a cover letter, if you are requesting any special budgeting (see #4.a. above). If you include a cover letter, explain the proposed budget to demonstrate that the spend-down should be zero. Make clear if you want the **Medicare Savings Program** too.

6. **How to send** your renewal packet to HRA:

   a. **Make two complete copies** of the signed renewal form and all attachments.

   b. **Mail** the original renewal packet and all required documents to HRA in the **barcoded gray envelope** you received in the mail. If you downloaded the form and you do not have the return bar-coded envelope, then mail it to the address below.

   c. **Mail** another complete copy of the renewal packet and all attachments in a separate envelope to the same address **via certified mail return receipt requested** so you have proof you sent it and when it was received. Save the return receipt.

PLEASE MAIL YOUR RENEWAL TO:
Mail Renewal Program
HRA/Medicaid Assistance Program
PO BOX 329060
Brooklyn, NY 11232-9823

   d. **Keep** one complete copy of the signed renewal packet and all attachments, along with the certified receipt for your records. This will be important if you receive a letter claiming HRA never received your renewal. See item 8 b. below.

7. After you send your renewal packet, you can call the automated line at **1-888-692-6116** to check the status of your renewal. Have your Medicaid case number available, which can be found on the top right corner of your renewal form. Be advised it may take some time for the renewal packet to be received and processed.

8. **TROUBLESHOOTING -- What if... ????**

   a. **You did not receive your renewal form by mail** or if you recently moved? See **Number 3** above.

   b. **You receive a *Notice* stating that your Medicaid will be discontinued for failure to renew,** even though you sent in your renewal. Sometimes this happens even when you submit your renewal on time -- because the computer is programmed to send them out automatically. A sample ***Notice of Decision on Your Medical Assistance*** is on page 8 of this packet. On this sample notice:

      - The DATE of the notice is August 21, 2019.
      - The missed deadline to submit the renewal was August 10, 2019.
      - The EFFECTIVE DATE of the Medicaid case closing is Sept. 3, 2019.

   If you receive this notice, **the only way to prevent your case from closing is to request a Fair Hearing with "Aid Continuing**" *before* the Effective Date of the discontinuance (case closing). In the *attached sample,* this date is September 3, 2019 (page 8 of this fact sheet).

WHEN to REQUEST THE FAIR HEARING -- The State hearing agency (NYS Office of Temporary & Disability Assistance or OTDA) must RECEIVE your fair hearing request ***before*** the *Effective Date of the case closing (Sept. 3, 2019 in the sample)*. Then your Medicaid will continue until the fair hearing is held and decided. This is called "Aid Continuing."

HOW TO REQUEST THE FAIR HEARING - by phone, fax, or online at https://otda.ny.gov/hearings/request/. Mail is not recommended as it may arrive too late for you to get Aid Continuing. Include a copy of your NOTICE, and write the date of the notice, the effective date, and the notice number on the Fair Hearing Request. The State hearing agency OTDA will alert HRA staff to keep your case open and your coverage active.

Find help for the hearing at https://www.lawhelpny.org/. Proof that you submitted your renewal on time (or within the 30-day grace period) will be important to win the hearing. Sometimes your advocate can help you avoid having a fair hearing altogether—but you must request the hearing with Aid Continuing right away to prevent loss of Medicaid and home care services.

c. **What if you are sending your renewal late?** In NYC, you have a 30-day grace period. HRA must accept the renewal up to 30 days after the case closing. In the sample notice on page 8, the renewal must be received by HRA within 30 days after September 3, 2019, which is by October 3, 2019. Mail it the same way described in No. 6 above or bring it to any Medicaid office so it is received within 30 days. If it is after 30 days, you must reapply for Medicaid. See NYC Medicaid Alert, *Reapplication & Renewal Grace Period* – July 31, 2019 at http://www.wnylc.com/health/download/687/.

WARNING: If you received the Notice that your Medicaid will be discontinued (like the sample on page 8), and if you did not send in the renewal, you must request a Fair Hearing before the case closing date to ensure your Medicaid case does not close. You should *also* submit the renewal to HRA within the 30-day grace period, if there is still time. But do not *only* submit the renewal even if you are in the grace period, or your Medicaid may be discontinued. Request a Fair Hearing too!

*** * ***

For questions -- contact the NYLAG Evelyn Frank Legal Resources Program:
212-613-7310 or eflrp@nylag.org (Monday, Wednesday 10 AM – 2 PM)
Check out http://www.wnylc.com/health/

This fact sheet is available online at http://www.wnylc.com/health/download/xxx/ and in this article at xxxx

Spanish version of this fact sheet is available at
http://www.wnylc.com/health/download/xxx/

Check online for updates!

MEDICAL ASSISTANCE PROGRAM
CASA VII MEDICAID ELIGIBILITY UNIT
3050 WEST 21STREET, 2ND FLOOR
BROOKLYN, NY 11224

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE.

SI USTED DESEA RECIBIR NOTIFICACIONES FUTURAS EN ESPANOL, POR FAVOR PONGASE EN CONTACTO CON SU TRABAJADOR(A).

PROGRAM CODE = 537

NOTICE NUMBER:	DATE:	CASE NUMBER:
N016PF0668	July 31, 2019	[redacted]

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
537		5H9SD	CASA VII MEDICAID ELIG. UNIT	888-692-6116

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	718-557-1399
OR Agency Conference	718-637-2426
Fair Hearing information and assistance	718-637-2426
Record Access	718-637-2425
Child/Teen Health Plan	718-557-1399

CASE NAME / AND ADDRESS

[redacted]

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

If you are blind or seriously visually impaired and need notices or other written materials in an alternative format (large print, audio, or data CD, or Braille), contact your local social services district.

MEDICAL ASSISTANCE

We have accepted your application dated July 24, 2019 for Medicaid with a spenddown requirement effective July 1, 2019 for:

Name	Client I.D. #
[redacted]	[redacted]

This is because your net income (gross income less Medicaid deductions) of $2,111.36 is over the allowable Medicaid income limit of $1,267.00. The amount over the limit is called excess income or spenddown. Your monthly excess income amount is $844.36.

Please look at the budget calculation section to see how we figured your excess income.

This means you will have to submit paid or unpaid medical expenses not covered by insurance which are equal to or more than your monthly excess income amount in order to be eligible for payment of any covered outpatient expenses. You may also pay your excess income amount to this agency for any month you need outpatient coverage.

You can become eligible for Medicaid for both inpatient and outpatient coverage if you become hospitalized and have medical expenses (paid or unpaid) that are equal to or more than your six-month excess income amount of $5,066.16, or have other medical expenses (paid or unpaid) that are equal to or more than your six-month excess income amount.

CONTINUED ON THE NEXT PAGE ...

NYC Human Resources Administration
Department of Social Services

MAP-909e (E) 06/17/2016

RENEWAL NOTIFICATION

LOCATION:
NOTICE DATE: July 10, 2019
CASE NUMBER:
NUMBER OF ADULTS:
NUMBER OF CHILDREN:
PRIORITY:
RVI CODE:
TELEPHONE NUMBER:

Closing Date

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 attach all required proofs. Return your entire renewal form, **including this page.**

You must respond by August 10, 2019 or your coverage may end**.** If your coverage ends, depending on the coverage that you have now, we will no longer be able to 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, 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.

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

- 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 disabled, proof of disability-related work (non-medical) expenses, if any;
- 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).

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

MEDICAL ASSISTANCE PROGRAM
MAIL RECERT.UNIT-DAB GPO BOX 2624
NEW YORK, NY 10117-0300

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE.

SAMPLE

NOTICE DATE

PROGRAM CODE = 508

SI USTED DESEA RECIBIR NOTIFICACIONES FUTURAS EN ESPANOL, POR FAVOR PONGASE EN CONTACTO CON SU TRABAJADOR(A).

NOTICE NUMBER: [redacted]	DATE: August 21, 2019	CASE NUMBER: [redacted]

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
MRM		[redacted]	MAIL RECERT. UNIT-DAB (MRTS)	888-692-6116

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	718-557-1399
OR Agency Conference	718-637-2426
Fair Hearing information and assistance	718-637-2426
Record Access	718-637-2425
Child/Teen Health Plan	718-557-1399

CASE NAME / AND ADDRESS

[redacted]

IF YOU DO NOT AGREE WITH ANY DECISION EXPLAINED IN THIS NOTICE, YOU HAVE A RIGHT TO ASK US FOR A CONFERENCE AND/OR ASK THE STATE FOR A FAIR HEARING. READ THE CONFERENCE AND/OR FAIR HEARING SECTION TO SEE HOW TO ASK FOR A CONFERENCE AND/OR A FAIR HEARING.

If you are blind or seriously visually impaired and need notices or other written materials in an alternative format (large print, audio, or data CD, or Braille), contact your local social services district.

MEDICAL ASSISTANCE

****
* *
* Even though you are no longer eligible for Medical Assistance, some members *
* of your case may be eligible for continuation/extension of their Medical *
* Assistance coverage. Please read this entire notice. *
* *
****

Effective date of Notice of discontinuance

We will discontinue Medicaid effective September 3, 2019.

You may request a Fair Hearing if you disagree with any decision explained in this notice. You have 60 days from the date of this notice to request a Fair Hearing. HOWEVER YOU MUST REQUEST A FAIR HEARING BEFORE THE EFFECTIVE DATE ABOVE IF YOU WANT YOUR MEDICAID TO CONTINUE UNCHANGED UNTIL THE FAIR HEARING DECISION. You may also request an informal local conference. A request for a local conference alone will not result in continuation of benefits and does not meet the 60-day deadline for requesting a Fair Hearing.

We are discontinuing Medicaid because you or your representative did not return the recertification form by August 10, 2019.

closing date

If your Medicaid is discontinued, all your Medicaid services, including your home care services, will be discontinued.

If you are now enrolled in a Medicaid Managed Care plan, you will no longer be

[redacted] [redacted]

CONTINUED ON THE NEXT PAGE ...