CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE

(DOCUMENTATION REQUIRED)

Human Resources Administration
Department of Social Services

MAP-751w (E) 03/25/2021

Note: This document is only to be used to correct/change the information listed on this form. To change a consumer's demographic information, staff is directed to MAP-751k, Consumer/Provider Request to Change Information on File (No Documentation Required).

Case Name: _____

Case Number: _____ CIN: _____

Please be advised that an eligibility notice will be sent regarding the change you requested.

CORRECT/CHANGE THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

☐ **Close Case Completely**

Additional Details: _____

Acceptable Proof

- Signatures of Consumer and/or Representative on this form

☐ **Combine Case**

Current Case Number: _____ With Case Number: _____

Additional Details: _____

Acceptable Proof

- Signatures of Consumer and/or Representative on this form

☐ **Add Individual to Case**

Name: _____

Additional Details: _____

Acceptable Proof

- DOH-4220, Access NY Application

☐ **Remove Individual from Case**

Additional Details: _____

Acceptable Proof

- Signatures of Consumer and/or Representative on this form

☐ **Notification of Death**

For: _____

Additional Details:

Acceptable Proof

- Death Certificate

☐ **Change in Immigration Status**

From: _____ To: _____

Additional Details: _____

Acceptable Proofs

- I-94 Arrival Departure Record
- I-551 Permanent Resident Card (Green Card)
- I-766 Employment Authorization Card
- I-797 Notice of Action indicating approval or pending application
- Evidence of continuous United States Residence prior to January 1, 1972
- Other authoritative documents that identifies a change in immigration status

☐ **Upgrade Eligibility to Include Personal Care/Other Community-Based Long-Term Care (CBLTC) Services/Nursing Home (NH) Services**

Additional Details: _____

Acceptable Proofs

- Proof of Income
- Proof of Resource (CBLTC: Resource documents for the current month only and NH: Resource documents for the past 60 months and an immediate need for the services)
- DOH-5178A, Access NY Supplement A

☐ **Medicare Savings Program Evaluation (MSP)**

Additional Details: _____

Acceptable Proofs

- See attached MAP-628j, Medicare Savings Program (MSP) Documentation Guide

  Note: If the documents on the MAP-628j were already submitted with your Medicaid application, you do not need to submit any additional documents.

☐ **Budgeting Changes**

☐ Disabled Adult Child (DAC) ☐ Medicaid Buy-In for Working People with Disabilities (MBI-WPD)

☐ Modified Adjusted Gross Income (MAGI) ☐ Pickle ☐ Reduce Spend Down

☐ Special Housing Standard after Discharged from Nursing Home or Adult Home and Enrolled in Managed Long-Term Care

☐ Spousal Impoverishment ☐ Spousal Refusal

Additional Details: _____

Acceptable Proofs

- See attached MAP-751x Budgeting Change Documentation Guide

☐ **Pooled Trust**

☐ Budgeting for New Trust Submission ☐ Budget for Increased Deposits

Additional Details: _____

Acceptable Proofs

- Copy of your Pooled Trust Joinder Agreement
- Copy of Power of Attorney (if applicable)
- Proof of Deposit Made
- Social Security Disability Determination or Disability Request (LDSS-486T Medical Report for Determination of Disability, LDSS-1151, Disability Review, MAP-751e, Authorization to Release Medical Information, OCA-960 Authorization for the Disclosure of Individual Health Information HIPAA Release Form)

☐ **Add or Remove Third Party Health Insurance**

Additional Details: _____

Acceptable Proofs

- MAP-404d, Notice of Health Insurance Confirmation
- MAP-404e, Notice of Removal of Third-Party Health Insurance
- MAP-404g, Request to Remove "Commercial" Third-Party Health Insurance

☐ **Coverage**

From: _____ To: _____

Additional Details: _____

Acceptable Proofs

- Medical Bills

☐ **Change Not Listed on this Form**

If a change you are requesting is not listed on this form, supply additional details in the space provided below:

_____

_____

NAME (PRINT)	SIGNATURE	DATE
CLIENT REPRESENTATIVE NAME (PRINT)	SIGNATURE	DATE

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.

Budgeting Change Documentation Checklist

Human Resources Administration
Department of Social Services

MAP-751x (E) 01/27/2021

Budgeting Change

Budget Type	Acceptable Proofs
Disabled Adult Child (DAC)	• Certified disabled or certified blind before age 22 • Received SSI benefits due to blindness or disability until the start of receiving Social Security Disabled Adult Child (DAC) benefits **and** • Have resources less than the Supplemental Security Income (SSI) resource level of $2,000.00
Medicaid Buy-In for Working People with Disabilities (MBI-WPD)	• Work in a paid position; ➢ Current pay stub(s), paycheck(s), income tax return, W-2 form, records of bank deposits, or a letter from the employer ○ If these are not available, a written statement from the employer stating the hours worked and wages paid may be accepted as proof of work • Self-employed ➢ A worksheet of the hours worked, for whom, and the income earned from each consumer (if more than one); • DOH-5029, Medical Report MBI-WPD Medical Report Continuing Disability Review (with 12 months of consumer's medical records and progress notes from all treating physicians) • LDSS-486T, Medical Report for Determination of Disability (with 12 months of consumer's medical records and progress notes from all treating physicians) • DOH-5178A, Access NY Supplement A • LDSS-639, Disability Review Team Certificate or LDSS-5144, Disability Review Team Certificate • LDSS-1151, Disability Questionnaire
Modified Gross Adjusted Income (MAGI)	• Care for a child or other relatives under 18 or under 19 in school

Budget Type	Acceptable Proofs
Pickle	• Receiving both Social Security Retirement Survivor's Disability Insurance (RDSI) and Supplemental Security Income (SSI) at the same time on, or after April 1977
Reduce Spend Down	• Proof of Income • Proof of Resources
Special Housing Standard after Discharged from Nursing Home/Adult Home Newly Enrolled in or Remained Enrolled in Managed Long-Term Care	• MAP-3057, Special Income Standard For Housing Expenses For Individuals Discharged From A Nursing/Adult Home Facility Who Enrolled into the Managed Long Term Care (MLTC) Program • Rent or other housing expenses • At least 30 days in a Facility
Spousal Impoverishment	• Spouse in a Nursing Home Eligibility Division (NHED)/Traumatic Brain Injury (TBI) Waiver and/or Managed Long-Term Care (MLTC) or immediate Need Program
Spousal Refusal	• MAP-2161, Applicant/Recipient Declaration Concerning the Legally Responsible Relative's Income/Resources

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MEDICARE SAVINGS PROGRAM (MSP)
DOCUMENTATION GUIDE

NYC Human Resources Administration
Department of Social Services

MAP-628j (E) 02/12/2018

Dear Medicare Savings Program Applicant:

The documents (proofs) listed below that apply, must be submitted with the signed application **for you and/or for each membe**r of your household requesting Medicare Savings Program coverage. Be sure to look at each of the four (4) categories listed below as more than one, or all, may apply to you. If you are applying by mail, please remember to send **photocopies only** of your documents. **Do not mail your originals.**

If you choose to apply in person, you may bring your original documents. We will make copies for our files for you.

In order to avoid the chance of our having to ask you for additional documents before we can complete our review, **please be sure to submit all needed proofs when you respond.**

1. PROOF OF INCOME (provide the documentation that applies)

Income Type	Type of Proof Required
Earned Income from Employer	Current paycheck/stubs (4 consecutive weeks) or letter from employer on company letterhead, signed and dated, current signed and dated income tax return and all Schedules, business/payroll records
Self-Employment Income	Current signed and dated income tax return and all Schedules, or record of earnings and expenses, business records
Rental/Roomer-Boarder Income	Letter from roomer, boarder, tenant or check stub
Unemployment Benefits	Award letter/certificate, benefit check, correspondence from the NYS Dept. of Labor
Private Pensions/Annuities	Statement from pension/annuity
Social Security	Award letter/certificate, annual benefit statement, correspondence from the Social Security Administration
Child Support/Alimony	Letter from person providing support, letter from court, child support/ alimony check stub, copy of NY Epicard with printout, copy of child support account information from www.newyorkchildsupport.com, copy of bank statement showing direct deposit
Worker's Compensation	Award letter, check stub
Veteran's Benefits	Award letter, benefit check stub, correspondence from the Veterans Administration
Military Pay	Award letter, check stub
Support from other Family Members or Friends	Signed statement and/or letter from family member or friend
Income from a Trust	Trust document indicating if you or your spouse received payments from or are a named beneficiary of a trust
Other: Supplemental Security Income (SSI) payments, student grants or loans	Letter indicating amount of assistance received or award letter/certificate

IDENTITY AND CITIZENSHIP OR CURRENT IMMIGRATION STATUS (provide the documentation that applies)

Category	Type of Proof Required
Citizenship/Identity	Copy of the front and back of your and your spouse's Medicare Card, if applicable **Note**: Consumers attesting to U.S. Citizenship, receipt of Medicare, is sufficient for proof of citizenship/identity; however, it cannot be used as proof of appropriate immigration status or identity for those consumers who are **not** U.S. Citizens.
Lawful Permanent Resident (LPR)/Immigrant	USCIS form I-551 "Green Card"
Other Qualified Immigration Status	Official Immigration documentation issued by the Federal Immigration Agency

2. RESIDENCY/HOME ADDRESS (provide any one of the following)

Type of Proof Accepted (Submit any one)

- Government ID card with address
- Driver's license issued within past 6 months
- School record showing address
- Letter/lease/rent receipt with home address from landlord
- Postmarked non-window envelope, postcard, or magazine label with name, address and date (**Note**: This items **canno**t be used if mailed to a P.O. Box)
- Utility bill within last six months (gas, electric, phone, fuel, water or cable), or correspondence from a government agency
- Property tax records or mortgage statement

3. HEALTH INSURANCE PREMIUMS (provide any one of the following, if applicable)

Type of Proof Accepted (Submit any one)

- Letter from employer
- Premium statement
- Premium statement

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Submitting Documentation to the Undercare Processing Unit

Human Resources Administration
Department of Social Services

MAP-3187 (E-S) 03/04/2022

How to Submit the MAP-751k Consumer/Provider Request to Change Information on File (No Documentation Required) or MAP-751w Consumer/Provider Request to Change Information on File (Documentation Required) to the Medical Assistance Program.

You may submit documentation in the following ways:

- Fax the documentation to 917-639-0837
- Mail the appropriate documentation to:

  MAP Undercare Processing Division
  785 Atlantic Ave, 5th Floor
  Brooklyn, NY 11238

If you are submitting the MAP-751w Consumer/Provider Request to Change Information on File (Documentation Required):

- Write your first and last name on the documents.
- Send only copies of your document and keep the original for your records.

Note: The Medical Assistance Program is unable to return documents sent for verification.

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.

Envío de documentación a la Unidad de procesamiento de Undercare (Undercare Processing Unit)

Human Resources Administration
Department of Social Services

MAP-3187 (E-S) 03/04/2022

Cómo enviar la solicitud MAP-751k del consumidor/proveedor para cambiar la información en el archivo (no se necesita documentación) o la solicitud MAP-751w del consumidor/proveedor para cambiar la información en el archivo (se necesita documentación) al Programa de Asistencia Médica.

Puede enviar documentación de las siguientes maneras:

- Envíe la documentación por fax al 917-639-0837
- Envíe por correo la documentación correspondiente a:

  MAP Undercare Processing Division
  785 Atlantic Ave, 5th Floor
  Brooklyn, NY 11238

Si envía la solicitud MAP-751w del consumidor/proveedor para cambiar la información en el archivo (se necesita documentación):

- Escriba su nombre y apellido en los documentos.
- Envíe solo copias de su documento y guarde el original para sus archivos.

Nota: El Programa de Asistencia Médica no puede devolver los documentos enviados para su verificación.

¿Tiene una condición o discapacidad médica o de salud mental? ¿Esta condición le dificulta entender este aviso o hacer lo que pide este aviso? ¿Esta condición hace que sea difícil para usted obtener otros servicios en la HRA? **Podemos ayudarlo.** Llámenos al **888-692-6116**. También puede solicitar ayuda cuando visite una oficina de la HRA. Por ley, tiene derecho a solicitar este tipo de ayuda.