8/22/2019 - date added by NYLAG from HRA MARC website

Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

Elimination of MAP-2097K

This Alert is to advise Providers, Health Plans (former Facilitated Enrollers), Community Based Organization and entities assisting consumers in recertifying or renewing their case that effective immediately, MAP-2097K Health Insurance Eligibility Screening Worksheet is obsolete and will not be needed and/or accepted as part of a renewal submission.

Renewal forms whether the MAP-909E or MAP-2096F (samples attached) are to be completed in their entirety; **all** pages of the renewal form must be submitted for the renewal to be processed, including the signature page.

Renewals with missing pages will be considered incomplete and will be deferred for the additional pages delaying the processing of the case.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration Department of Social Services
Medical Assistance Program • Office of Eligibility Information Services • 785 Atlantic Avenue, Brooklyn, NY 11238
Steven Banks, *Commissioner* ♦ **Karen Lane,** *Executive Deputy Commissioner* ♦ **Maria Ortiz-Quezada**, *Director of EIS*

< insert return address
snippet 1a>

Human Resources Administration
Department of Social Services

MAP-909e (E) 04/19/2018

RENEWAL NOTIFICATION

< insert snippet 1b,1c,1d or 1e) >

LOCATION:
NOTICE DATE:
CASE NUMBER:
NUMBER OF ADULTS:
NUMBER OF CHILDREN:
PRIORITY:
RVI CODE:
TELEPHONE NUMBER:

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 **before < insert date – snippet 1f >** 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

< insert Consumer 's Name and Case Number >

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.

< insert snippet 2a or 2b >

1. **HOUSEHOLD INFORMATION:** This section is printed with the names of family members on your case.
   - Update the information if it is wrong or if it has changed.
     - If there is no change in household, check the "No Change" box.
   - 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.
   - 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						**[ ]**
2						**[ ]**
3						**[ ]**

2. **ADDRESS WHERE YOU LIVE**: **(No Proof Required)**

	No Change **[ ]**
Secondary Address for Notices (if provided)	No Change **[ ]**
Housing/Rent Payment: How Often?	No Change **[ ]**

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:** (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	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
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]

6. **RESOURCES**: (No Proof Required Unless Indicated Below)

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. **Do not list your home**.

< insert snippet 4a and/or 4 b>

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
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]

< insert snippet 4c or 4d >

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 $ **insert snippet 5a ?** ☐ Yes ☐ No

< insert snippet 5b or 5c >

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 expense 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 disabled, do they have to pay special expenses (non-medical) in order to work? ☐ Yes ☐ No

If Yes:

Work Related Expense	How Often

10. VISUAL DISABILITY: (No Proof Required)

If you have a visual disability that makes reading this notice difficult, we are working to provide many of our notices to you in large print, audio cd, data cd or Braille. 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:

☐ Large Print ☐ Data CD

☐ Audio CD ☐ Braille

Also, fill in below:

The language that I speak is: _____

The language that I read is: _____

We have written notices in English, Spanish, Arabic, Chinese (Traditional), Haitian-Creole, Korean Russian, Bengali, Chinese (Simplified), French, Polish, and Urdu.

Please be sure that you answered all the questions on this form, in all the sections. **Remember to sign Page 7.**

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

(Remainder of page left blank intentionally)

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 8 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 s/he may have chosen to provide at this time by completing Page 8 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: _____

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 you are earning $1,000 per month with rent/mortgage of $500 per month, 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 you are earning $1,000 per month with rent/mortgage of $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 $ _____

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 212-331-4640. 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.

NYC Human Resources Administration
Department of Social Services

MAIL TO:
Mail Renewal Program
HRA/Medical Assistance Program
PO Box 329060
Brooklyn, NY 11232-9823

MEDICAID/FAMILY HEALTH PLUS
(FHPlus) RENEWAL FORM

LOCATION:
NOTICE DATE:
CASE NUMBER:
NUMBER OF ADULTS:
NUMBER OF CHILDREN:
PRIORITY :
RVI CODE :

Carefully read the "**guide booklet**" that came with this form before you begin to answer any questions. To allow us to determine if you can continue receiving Medicaid or Family Health Plus (FHPlus), you **must**:

1. Answer all questions on this form.
2. Look for instructions about **sending proof** in each section of the form. If the instructions tell you to **Send Proof** (documents), see the enclosed **Documentation Guide** for a list of what we accept.
3. Sign and return **this form and all needed proofs (documents)** in the enclosed envelope.

If we do not receive this form and the needed proofs in our office **before <insert date> ,** your Medicaid/FHPlus **will end.**

❶ HOUSEHOLD MEMBERS ON YOUR MEDICAID CASE:

- If someone has **left** the household, **cross-out** her/his name.
- If "**Add SSN"** is printed in the Social Security Number (SSN) column for any person, **write-in** the SSN.
  - If that person does not have a SSN, send the most current dated form **SSA-5028** from the Social Security Administration (SSA) or a signed letter from SSA confirming that this person has applied for a SSN.
- If "**Send Proof**" is printed in the Citizenship/Immigration Status column, or your status has changed, send the most recent letter received from the federal immigration agency or other proof of current citizenship/immigration status.
- If you are declaring to be a U.S. citizen, place a "C" in the Citizenship/Immigration column. You do not need to send proof at this time. If documents are needed, you will receive a letter requesting them.

	Name	Date of Birth	Sex (M/F)	Social Security Number (SSN)	Citizenship/ Immigration Status	No Change
01						[ ]
02						[ ]
03						[ ]
04						[ ]
05						[ ]
06						[ ]
07						[ ]
08						[ ]
09						[ ]
10						[ ]
11						[ ]
12						[ ]

( ) X Indicates additional household members are on the case.

❷ **ADDRESS AND TELEPHONE NUMBER**: Is the address and telephone number printed below correct?

- If it is **correct,** check the "**No Change**" box.
- If it is not correct, write in the most current information.

		No Change
Address:		[ ]
Phone Number:	Alternate Phone Number:	[ ]

❸ **INCOME:** Write-in income information for anyone listed in Section ❶ and anyone in the household who is a parent, step-parent, or spouse of those listed in Section❶. **If you may be eligible for Medicaid with a surplus (Surplus Income Program), Send 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)
			$	
			$	
			$	
			$	

If any part of your salary/income is paid in cash, check "Yes" ----------→ For example, if you receive both a paycheck and cash tips, check "Yes."	☐ Yes ☐ No
Persons with **No** Income • If **no** adult member of your household has income, check this box ----------→ • If one or more adults in your household **have** income, list the names of the adults, if any, who do **not** have income _____	☐ No adults with income in household
If **no one** in your household has income, please explain how your are meeting your living expenses : _____ _____	
• Do you receive free housing as part of your pay? ----------→	☐ Yes ☐ No

❹ **OTHER HEALTH INSURANCE:** Tell us if anyone on this case has other health insurance. Send copy of front and back of health insurance card for each person who has other health insurance, if you have **no**t submitted it before. Do **not** list persons who **only** have Medicaid, Family Health Plus, Child Health Plus or Family Planning Benefit Program coverage. **Send Proof of payment of any other health care premium expenses other than Medicare.**

Note: Leaving this section blank will indicate that no one on this case has other health insurance.

Name of Insured Person	Name of Insurer	Premium Amount (if known)	How Often Paid (if known)

Does anyone on this case have a spouse or parent who can provide health insurance for them, but does not at this time? ----------→	☐ Yes ☐ No

If "Yes," who? (list all): 1._____ 2._____ 3._____ 4._____ 5. _____	
Name of spouse or parent: ----------→ Address of spouse or parent: ----------→	_____ _____

❺ **PREGNANCY:** Tell us if anyone listed in Section ❶ is pregnant. (Pregnant women do **not** need to provide **SSN** or prove immigration status.)

Is anyone on this case pregnant? ----------→	☐ Yes ☐ No
If "Yes," **Send Proof.** **We need a letter from a medical provider verifying the pregnancy and expected date of delivery.**	
Name of pregnant woman:	Expected date of delivery**:**

❻ **EXPENSES:** Write-in how much you pay for (your share of) housing/rent for your household and how much you pay for childcare/dependent care. **If you may be eligible for Medicaid with a surplus (Surplus Income Program),** **Send Proof** of childcare/dependent care expenses.

Housing/Rent: $ How Often:	Childcare/Dependent Care: $ How Often:

❼ **LANGUAGE:**

What language do you prefer to **read**? _____ What language do you prefer to **speak**? _____

❽ **OTHER PEOPLE IN HOUSEHOLD:** Write in the names of all persons in the household who are **not on this case** and tell us how they are related to someone listed in Section ❶

Name of Person	Age	Name of Person Listed in Section ❶	Relationship to Person Listed in Section ❶

I certify under penalty of perjury that everything on this application is the truth as best I know. I have also read and understand the *Terms, Rights and Responsibilities*.

SIGN HERE ☞

Signature of Consumer:

_____ Date:_____

Signature of Legally Responsible Relative (if applicable):

_____ Date: _____

FOR OFFICE USE ONLY: To be completed by the person assisting with this Renewal Form

Signature of Person Who Obtained Eligibility Information _____	Employed By (Check one) ☐ Community-Based Facilitated Enrollment Agency ☐ Health Plan ☐ Social Services District ☐ Provider Agency ☐ Qualified Entities Employer Name: _____

TO BE COMPLETED BY THE MEDICAL ASSISTANCE PROGRAM	
Worker Signature	Date
Supervisor Signature	Date

Financial Maintenance at Renewal

Important Notice: This form only needs to be completed if your household's share of the monthly expense for housing exceeds 70% of the total gross income for all household members. Most consumers are **not** required to complete the form below. It has been added to this Renewal Application booklet **only in case** you need to complete it.

For example: if you are earning $1,000 per month with a rent/mortgage expense of $500 per month, you only have a 50% ($500/$1000) expense level and do **not** need to complete this form. However, if you are earning $1,000 per month with a rent/mortgage expense of $800 per month, you have an 80% ($800/$1000) expense level and **need** to complete this form.

If you know that this form applies to you, please complete and sign it now. If you are not sure, you can choose to complete or you can 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 in front of it and write-in the monthly amount spent on each item		Explain how you pay for each of the monthly living expenses (such as cash on hand, checking/savings account monies, income/wages, credit cards, help from others). List the names and relationship to you of anyone providing help, or make a note if the expense has not been paid and for 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 $ _____

Applicants/Recipients must read the following and sign Page 3 of this booklet

By having signed Page 3 of this Renewal booklet, I certify that all of the above information, if any, is true and correct. I understand that this information is to be used to determine eligibility for Public Health Insurance Programs. I also understand that if I intentionally misrepresent my situation, I may have to repay benefits received and may be subjected to prosecution under State law.

Facilitated Enrollers (if assisting consumer) must read the following and sign Page 3 of this booklet

By having signed Page 3 of this Renewal booklet, I certify that the information reported on this form was provided solely by the applicant/recipient. 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 under State law.