NYC Human Resources Administration
Department of Social Services

Medical Assistance Program (MAP)

MEDICAID ALERT

Updated **September 8, 2021**

Medical Assistance Program Undercare Division

This Alert is to advise Medicaid Providers, Hospitals, Client Representatives, Community Based Organizations, Advocates, that the Medical Assistance Program's Undercare Division can now receive case action update requests via their email address. This email is **not** for new applications. The program has no ability to send a confirmation to agencies acknowledging receipt of requested action.

Effective immediately, please submit undercare case actions to undercareproviderrelations@hra.nyc.gov. Please ensure that your encrypted email includes:

- The topic of your inquiry in the subject line.
- Your first name, last name, Provider/Agency's name, and contact number.
- The appropriate completed and signed MAP-751 form (both forms are attached).
  - The **MAP-751K** is used for undercare changes when documents are not required.
  - The **MAP-751W** is used for undercare changes when the action or change requires documentation.
  - **Note:** Only the current version of the forms will be accepted.
- The Consumer/Client's Full Name, Client Identification Number (CIN), and Case Number (if available).
- A brief description of your inquiry/request.
- Documents that verify the need for the case action update request (when necessary).
- Requests for multiple clients can be submitted in one email (label each form with consumer's demographic info such as name, CIN, etc.). Please submit the appropriate completed MAP-751 form for each client.

Actions will be completed within a reasonable time frame; cases are processed in the order received. If you have an inquiry about your submission, please send a follow up email using the original email you submitted with your request.

Consumers will be notified of completed actions by mail.

For those representatives with no email capability the request with appropriate 751 form can still be faxed to **917 639-0837.**

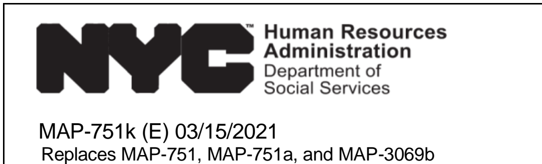
This division can complete transactions such as, but not limited to, demographic changes, change of address, transfer from county to county requests, and coverage updates.

Consumers will be sent a notice regarding any action taken on their case.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE

(No Documentation Required)



MAP-751k (E) 03/15/2021
Replaces MAP-751, MAP-751a, and MAP-3069b

Case Name: ______________________________

Case Number: ____________________ CIN: ____________________

Change is for: ______________________________

A. CORRECT/ADD THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

☐ **Change Name**

From: ____________________

To: ____________________

☐ **Add/Correct Social Security Number (SSN)**

From: ____________________

To: ____________________

☐ **Correct Date of Birth**

From: ____________________

To: ____________________

☐ **Add/Change Phone Number**

From: ____________________

To: ____________________

☐ **Correct Gender Information**

From: ______________________________

To: ______________________________

☐ **Change Residency Address**

From: ______________________________

To: ______________________________

☐ **Change Mailing Address**

From: ______________________________

To: ______________________________

☐ **Add/Change Secondary Mailing Address**

From: ______________________________

To: ______________________________

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

Language Spoken

☐ **Language Spoken** From: ______________________ To: ______________________

Language Read

We have notices available in the following languages:

- English
- Spanish
- Arabic
- Bengali
- French
- Haitian Creole
- Korean
- Polish
- Russian
- Simplified Chinese
- Traditional Chinese
- Urdu

Tell us what language you want your notices sent to you.

☐ **Language Read** From: ______________________ To: ______________________

Alternative Format/Visual Impairment

Do you have a visual disability that makes reading notices difficult? We can give you notices in the following formats. Tell us how you want your notices sent to you:

☐ **Large Print** ☐ **Audio CD** ☐ **Data CD** ☐ **Braille**

B. PROVIDER INFORMATION (TO BE COMPLETED BY PROVIDERS ONLY)

Note: This section is not to be used for Home Care Services Program Providers submissions.

Provider Name: ______________________

Provider Address: ______________________

Provider Code: ______________________ Original Determination Date: ______________________

Admission Date: ____________ Admission Number: ____________ Discharge Date: ____________

Phone Number: ______________________ Fax Number: ______________________

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.

CONSUMER/PROVIDER REQUEST TO CHANGE INFORMATION ON FILE

(DOCUMENTATION REQUIRED)

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:

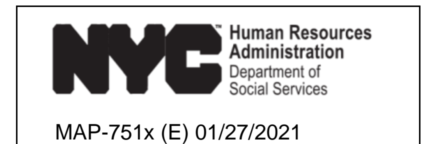
____

____

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



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 o 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

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.

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

MEDICARE SAVINGS PROGRAM (MSP)
DOCUMENTATION GUIDE

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 member** 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
- 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)
- Driver's license issued within past 6 months
- Utility bill within last six months (gas, electric, phone, fuel, water or cable), or correspondence from a government agency
- School record showing address
- Property tax records or mortgage statement
- Letter/lease/rent receipt with home address from landlord

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

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.