# REQUEST FOR EXEMPTION

☐ Exemption Approved ☐ Exemption Not Approved
Authorized Signature: _____
Print Name: _____
Date: _____Reason: _____

**What is an Exemption?**
An exemption means you do **not** have to join a Medicaid health plan. If you are in a health plan now and you get an exemption, you will be disenrolled from your Medicaid health plan.

**How to apply for an exemption:**

1. Section A needs to be completed by the Medicaid applicant/recipient or authorized person assisting him/her.
2. Sections B and F must be completed by your Health Care Provider/Professional.
3. Sections D and E ask for documentation; please be sure to send in the papers asked for.
4. Mail or fax the form and papers to the Managed Care Unit at your Local Department of Social Services (LDSS).

Please note that Sections B through E only need to be completed if they apply to you.

SECTION A **Please Fill Out This Section**

Please Print

Name of Medicaid applicant/recipient asking for an exemption: ID # (NYS Benefit Card):

Street Address (No P.O. Boxes): Apt #: City: Zip Code:

Name of Head of Household (if different): Telephone # where you can be reached

Relationship to Head of Household: ☐ self ☐ other

**I understand the following:**

- I am asking for an exemption from the Medicaid managed care program. I do not want to join a health plan.
- I understand that if I am now in a Medicaid health plan and I am approved for an exemption, I will be disenrolled from my health plan.
- I know that to ask for the exemption, I may need to give information about my medical condition. I give my provider permission to give the Local District of Social Services all needed medical information only if it is relevant to my request for the exemption. This may include mental health, HIV, alcohol or substance abuse, or disability information, if it is needed for this exemption request.

**Signature:** **Date:**

**If you need help with filling out this form, please call the Managed Care Unit at your Local Department of Social Services.**



SECTION B **Medical/Health**

**Health Care Provider / Professional: Please complete numbers 1-8, as applicable. You must also complete and sign Box 9. By completing and signing this form, you are attesting that you do not participate with any of the Medicaid managed care plans but you do participate with fee-for-service Medicaid.**

☐ **1.** I provide prenatal care to this patient and **I do not participate** in a Medicaid health plan.
Date of patient's last visit: Due date (EDC):

☐ **2.** I provide medical care to this patient who is scheduled for major surgery within 30 days after managed care enrollment and **I do not participate** in a Medicaid health plan.
Date of patient's last visit: Surgery date:

☐ **3.** I have been this patient's **primary care provider** for at least one year and **I do not participate** in a Medicaid health plan.

☐ **4.** I am a medical specialist practicing one or more of the medical specialties listed below and providing medical care to this patient for at least 6 months and **I do not participate** in a Medicaid health plan.

**List of Medical Specialties**

| | | |
|---|---|---|
| **Allergy and Immunology** | **Cardiology** | **Endocrinology** |
| **ENT Surgery** | **Gastroenterology** | **Hematology** |
| **Infectious Disease** | **Nephrology** | **Neurology** |
| **Oncology** | **Opthamology** | **Orthopedic Surgery** |
| **Psychiatry** | **Physiatry (Rehabilitative Medicine)** | **Plastic Surgery (Non Cosmetic)** |
| **Pulmonology** | **Rheumatology** | **Other (as approved by NYSDOH)** |

Patient's condition(s)/ diagnosis(es): Date of patient's last visit:

I have been providing care since: Estimated date of completion of treatment, if applicable:

☐ **5.** I provide medical care to the person requesting an exemption and s/he has (check one):

☐ HIV/ AIDS ☐ End-stage renal disease (ESRD)

☐ **6. The patient needs care in the home or in the community as a result of a physical or developmental disability. (A developmental disability is a disability that occurred before age 22 and has substantial lifelong functional impairments.) The patient receives coordinated care/services intended to address health care needs, severe behavior problems and/or adaptive behavior deficits. Note: A physician, or in the case of developmental disabilities, a Qualified Mental Retardation Professional must check box and complete #9.**

My patient's care meets **all** of the following criteria:

- Requires extensive and/or complex care in their home or community for at least 120 days; and
- This care allows the patient to stay in their home or in the community in lieu of being in an institutional setting (such as permanent or long-term placement in a nursing home, intermediate care facility, hospital or skilled nursing facility); and
- A physician and/or qualified health professional have ordered these services.





☐ **7.** My patient is a resident of (facility name and address):

_____

_____

☐ a chemical dependence long term residential program and is expected to stay

from:_____ until _____
(date) (date)

☐ **8.** I am a psychiatrist, psychologist or Licensed Clinical Social Worker (LCSW). My patient is an adult who is seriously and persistently mentally ill, or a child who is seriously emotionally disturbed. She/he does not have SSI, nor is certified blind or disabled. My patient has utilized the services that I have checked below during the last 12 months:

☐ Ten or more encounters, including visits to a mental health clinic, psychiatrist, or psychologist and inpatient hospital days relating to a psychiatric diagnosis; **OR**

☐ One or more specialty mental health visits (i.e., psychiatric rehabilitation treatment program; day treatment; continuing day treatment; comprehensive case management; partial hospitalization; rehabilitation services provided to residents of OMH licensed community residents and family based treatment; and mental health clinics for seriously emotionally disturbed children).

☐ **9. Provider Information/Signature** **Must be completed and signed by Provider**

Date _____
Provider/Physician*: (please print) License #:

_____

Specialty: MMIS/NPI Provider ID#:

_____

Office/ Clinic Address:

City: Zip Code: Fax #: ( )

Signature: Phone #: ( )

* Must be signed by an Attending Physician or by a Qualified Mental Retardation Profession for Section D.6.





**SECTION C No Medicaid Health Plan Doctor Near Your Home**

There are no Medicaid health plan doctors within 30 minutes or 30 miles of your home.

The names of the 2 streets
that cross each other nearest you: _____and_____

Address of your current doctor (or clinic)_____

**SECTION D Living Outside Your County for a Short Time Only**

You must send some official paper showing that you are temporarily living outside the County where you receive Medicaid. For example, you can send a letter from your child's school saying that your child is a student there.

Your current temporary address: _____.

Zip Code: _____ How long you will be at this address: _____.

**SECTION E Native Americans**

Please provide a copy of official documentation of your Native American status and other family members who are Native Americans living with you who do not want to join a health plan.

**SECTION F Language**

What is your Language? _____

☐ I cannot speak about my medical needs in English.

☐ I cannot find any Medicaid health plan doctor whom I can speak with about my medical needs in my language.

I hereby certify that I speak the applicant's primary language, which is other than English, or that I have a staff person capable of translating medical terminology in the applicant's language, which is other than English.

I further certify that I am a fee-for-service provider in the Medicaid program. I do not participate in any of the managed care plans under contract with the Medicaid program.

**Health Care Provider**: Complete and sign.

Date: Provider/Physician*: License # .

Specialty: MMIS Provider ID# .

Office/Clinic Address: .

City: Zip Code: Phone: ( ) Fax: ( ) .

Signature: .
*Must be signed by an Attending Physician.

**Contact the Managed Care Unit at your Local Department of Social Services for assistance in completing this form.**

**Information provided in this form is subject to verification by the New York State Department of Health and/or Local Department of Social Services (LDSS).**