Section F Living outside your County for a short time only.

You do not have to join a health plan if you are living outside of your county right now.

1. Sign section **A** of the form.
2. Check the box at the top of section **F** .
3. Fill out section **F** of the form.
4. Get a letter of proof written on letterhead from an institution such as your child's school saying that your child is a student there. You may also include the names of other family members who are temporarily living outside of your county with you.

Section G Native Americans

You do not have to join a health plan if you are a Native American.

1. Sign section **A** of the form.
2. Check the box at the top of section **G**.
3. Get a copy of one of the following documents: Bureau of Indian Affairs, Tribal Health, Resolution, Long House or Canadian Department of Indian Affairs identification cards; documentation of roll or band number, documentation of parents' or grandparents' roll or band number together with birth certificate(s) or baptismal record indicating descendance from the parents or grandparents; or a notarized letter from a federal or state recognized American Indian/Alaska Native/Tribe Village Office stating heritage or a birth certificate indicating heritage.
4. You may also include the names of other family members who are Native Americans living with you who do not want to join a health plan.

Ask to talk to an Exemption Counselor.
This call is free and confidential.

New York Medicaid CHOICE
1-800-505-5678
TTY/TDD: 1-888-329-1541

UN-EX-CVR-E-0609

EXEMPTION APPLICATION

Reasons You Can Apply For An Exemption

- **No Medicaid health plan doctor near your home:** Sign section A and fill out section B.
- **Foster Care Children** *(does not apply to all counties):* Sign section A and fill out section C and provide documentation.
- **Primary Care Provider does not accept Medicaid health plans.** Sign section A and ask your doctor to fill out section D.
- **Medical/Health:** Sign section A and ask your doctor to fill out section D.
- **Language:** Sign section A, fill out top and check box at section E and ask your doctor to fill out section E.
- **Living outside your County for a short time only:** Sign section A and fill out section F and provide documentation.
- **Native Americans:** Sign section A and follow the instructions in section G.
- **Physical or Developmental disabilities with extensive needs similar to people in Medicaid Home and Community Based Services waiver programs or Intermediate Care Facilities.** Sign section A and ask your doctor to fill out section D.6.
- **Homeless and/or living in a shelter** Sign section H and fill out section I.
- **Long Term Alcohol and Substance Abuse Program** Sign section H and fill out section J.

Mail this form and papers, (if required) **to:**

New York Medicaid CHOICE
P. O. Box 5009
New York, New York 10274-5009

Use the envelope provided.
You do not need a stamp.

New York Medicaid CHOICE will send you a letter about your exemption request.

Need help?

New York Medicaid CHOICE
1-800-505-5678
TTY/TDD: 1-888-329-1541

Instructions

More **Instructions** ➔

Section A Everyone MUST sign section A.

Section B No Medicaid health plan doctor near your home.

You do not have to join a health plan if you cannot find a doctor in a Medicaid health plan within 30 minutes or 30 miles of your home.

1. Sign section **A** of the form.
2. Check the box at the top of section **B**.
3. Fill out section **B** of the form.

Section C **Foster Care Children.** Does not apply to all Counties.

Children in foster care do not have to join a health plan.
Call the HelpLine to find out if this exemption applies to the area where you live.

1. Sign section **A** of the form and check the box at the top of Section **C**.
2. Fill out Section **C**.
3. Get a letter from the foster care agency on letterhead saying that the child (children) are in foster care.

Section D Medical/Health

You do not need to join a health plan if any of the reasons below applies to you.

- You are **pregnant** and you are already getting prenatal care from a medical provider who is not in a Medicaid health plan.
- You are scheduled for major **surgery** and your doctor is not in a Medicaid health plan.
- You have been going for at least one year to a **primary care provider** who is not in a Medicaid health plan.
- You have a **disability or a chronic condition,** and you have been going for 6 months or more to a specialist who is not in a Medicaid health plan
- You have a **diagnosis of HIV+ or AIDS.**
  (Note: Doctors and providers should call 1-888-9EXEMPT to learn if this exemption reason applies to your patient.)
- You have **kidney disease** and you are on dialysis.
- You have a **physical or developmental disability** and you are receiving extensive care in the home or in the community similar to people in Medicaid Home and Community Based Services waiver programs.
- You are a resident of an **intermediate care facility for the mentally retarded** or have similar needs.
- You are an adult who is **seriously and persistently mentally ill** or you are a child who is **seriously emotionally disturbed** and have received treatment within the last 12 months.
  (This exemption does not apply to patients who have SSI or who are certified blind or disabled.)

1. Sign section **A** of the form.
2. Check the box at the top of section **D**.
3. Ask your doctor, specialist or medical professional to fill out section **D**. This section can only be filled out for one person.

Section E Language

If you cannot find a doctor (or staff person) in a Medicaid health plan who speaks your language, then you can apply for an exemption.

1. Sign section **A** of the form.
2. Check the box and complete the top of section **E**.
3. You may include the names of other family members who live with you and who do not understand English.
4. Ask your doctor to fill out the Provider's part of section **E**.