MEDICAID & MSP

ACCESS NY HEALTH CARE Medicaid / Family Health Plus / Child Health Plus

Since this new application is used for various public health insurance programs, be sure to indicate, at the top of the page, the name of the program for which you are applying.
Ex: MEDICAID and MSP

PLEASE READ the entire application and INSTRUCTIONS before you fill it out. Print clearly in blue or black ink. An incomplete application cannot be processed and will result in a delay of

Section A Applicant's Information

Please tell us who you are and how to contact you.

Legal First Name: JANE | Middle Initial: | Legal Last Name: DOE

Primary Phone #: 212-345-6789 ☒ Home ☐ Cell ☐ Work ☐ Other

Another Phone # ☐ Home ☐ Cell ☐ Work ☐ Other

What Language Do You Speak? English Read? English

HOME ADDRESS of the persons applying for health insurance — SEND PROOF

☐ Check here if homeless

Street: 520 Eighth Avenue | Apt.#: 5F

City: New York | State: NY | Zip Code: 10018 | County: NY

MAILING ADDRESS of the persons applying for health insurance if different from above.

Street: | Apt.#:

City: | State: | Zip Code:

This field allows the Medicaid applicant to name a third party to receive notices, correspondence, and recertification forms related to his/her Medicaid. It is not clear whether this feature is operable. You can complete this information but the Medicaid applicant should expect to receive the correspondence directly.

The Medicaid applicant can sign a MAP 751 D (HIPPA) to authorize another person to speak to Medicaid about his/her case.

OPTIONAL: If there is another person you would like to receive your Medicaid notices, please provide this person's contact information. I want this contact person to:

Check all that apply:
☒ Apply for and/or renew Medicaid for me
☐ Discuss my Medicaid application or case, if needed
☒ Get notices and correspondence

Name: Susie Doe

Street: 620 Seventh Ave | Apt.#: 3F

City: New York, NY 10018

Section B Household Information

If you live in the household, start with yourself. If you do not, start with any adults who

the persons applying for or already receiving Medicaid, Family Health Plus or Child Health Plus **and list the ID Number from their Bene**

for house and spouses. You may provide information for other household members (for

Listing ot u a higher eligibility level. Pregnant women and children under 19 may be

SSI and Medicare beneficiaries must still provide proof of birth and identity.

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women SEND PROOF	*Race/ Ethnic Group
01	JANE DOE JANE SMITH Full Maiden Name (person's birth name before they were married) City of Birth: JONES State of Birth: Country of Birth: GERMANY This Person's Mother's Full Maiden Name	01/01/1970 ☐ Male ☒ Female	☐ Yes ☒ No	☐ Yes ☒ No What is the Due Date? / /	☐ Yes ☒ No	SELF	☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known: N/A	123-45-6789	☒ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status	W
02	JESSIE DOE (DAUGHTER - NOT APPLYING) Full Maiden Name (person's birth name before they were married) City of Birth: NY State of Birth: NY Country of Birth: USA This Person's Mother's Full Maiden Name: SMITH	04/04/1945 ☐ Male ☒ Female	☐ Yes ☒ No	☐ Yes ☒ No What is the Due Date? / /	☐ Yes ☒ No	daughter	☐ Child Health Plus ☐ Medicaid	764-35-2189	☐ Non-immigrant (Visa holder) ☐ None of the above	W

SSI and Medicare beneficiaries are exempt from having to document their citizenship status. Instead, these applicants would have to provide a copy of their Medicare cards or SSI award letters with their applications.

If the person(s) you are living with is not applying (spouse or another family member), you should still provide his/her information, and then indicate clearly that he/she is not applying.

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible

SEND PROOF **Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Do** **list of documents that prove Identity, Citizenship or Immigration Status.**

***Race/Ethnic Group Codes (optional):** A-Asian, B-Black or African-American, I- Native American or Alaskan Native, P- Native H **own. Please also tell us if you are Hispanic or Latino-H**

NYS DOH (Continued on page 2)

Section B Household Information (Continued from previous page)

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women SEND PROOF	*Race/ Ethnic Group
03	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name ☐	/ / ☐Male ☐ Female	☐ Yes ☐No	☐ Yes ☐No What is the Due Date? / /	☐ Yes ☐No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ ☐ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
04	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐Male ☐ Female	☐ Yes ☐No	☐ Yes ☐No What is the Due Date? / /	☐ Yes ☐No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
05	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐Male ☐ Female	☐ Yes ☐No	☐ Yes ☐No What is the Due Date? / /	☐ Yes ☐No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
06	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐Male ☐ Female	☐ Yes ☐No	☐ Yes ☐No What is the Due Date? / /	☐ Yes ☐No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
07	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐Male ☐ Female	☐ Yes ☐No	☐ Yes ☐No What is the Due Date? / /	☐ Yes ☐No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder)	

Is anyone in your household a veteran? ☐ Yes ☒ No If yes, name: _____

This question pertains to the applicant's veteran status, please answer.

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

SEND PROOF **Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of document** **Immigration Status.**

***Race/Ethnic Group Codes (optional):** A-Asian, B-Black or African-American, I- Native American or Alaskan Native, P- Native Hawaiian or other Pacific Islander, W-White, U-Unknown. Please also tell us if you are Hispanic or Latino-H

Section C Household Income

Write the types of money and the amount received by everyone listed in Section B and SEND PROOF

Earnings from Work: Includes wages, salaries, commissions, tips, overtime, self-employment. If you are self-employed check here: ☐ Check here if no earnings from work: ☒

Name of Person	Type of Income/Employer Name	How Much? (before taxes)	How Often? (we

Unearned Income: Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veterans' benefits, Workers' Compensation, child support payments/alimony, rental income, pension, annuities and trust income. Check here if no unearned income: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (we
JANE DOE	SOCIAL SECURITY	$901.50	MONTHLY
↓	PENSION	$240.00	MONTHLY
	IRA DISTRIBUTIONS	$900.00	YEARLY
	HOLOCAUST REPARATIONS	$350.00 (EXEMPT)	MONTHLY

Contributions: Money from relatives or friends, roomers or boarders (include money that anyone gives you each month to help meet living expenses). ☒ Check here if

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (we

Other: Temporary (cash) Assistance, Supplemental Security Income (SSI) payments, student grants, or loans. Check here if none: ☒

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

For all income sources, you want to indicate the MONTHLY GROSS AMOUNT.

IRA REMINDER: For those applicants, in the Disabled, Aged, and Blind category, if they have an IRA and it is in pay status, the distributions they receive monthly, quarterly, or yearly COUNT AS INCOME and must be reported.

REPARATIONS REMINDER: If the applicant receives reparations because he/she is a Holocaust Survivor, he/she must report these payments even if they are EXEMPT. He/she must submit proof that these are exempt funds.

1. Do you or any applying adult in Section B have no income? ☒ No ☐ Yes Who? _____

2. If there is no income listed above, please explain how you are living:
(For example: living with friend or relative) My daughter Susie pays $300 to my landlord directly every month

3. Have you or anyone who is applying changed jobs or stopped working in the last 3 months? ☒ No ☐ Yes
If yes: Your last job was: Date ____/____/____ Name of Employer:

4. Are you or anyone who is applying a student in a vocational, undergraduate, or graduate program? ☒ No ☐ Yes
If yes: ☐ Full Time ☐ Part Time ☐ Undergraduate ☐ Graduate Student's Name:

5. Do you have to pay for childcare (or for care of a disabled adult) in order to work or go to school? ☒ No ☐ Yes

Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)

Question 2: If an applicant's family member/friend is providing in-kind support (paying rent, utilities etc), then indicate the amount of the support provided, the name of the person providing it, and the kind of support it is.

REMINDER: A letter written by the family member/friend providing the support or a completed MAP 2050A "Declaration of Income or Support" form must be submitted with the application.

6. If you are not eligible for Medicaid or Family Health Plus coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only? ☒ No ☐ Yes

Section D Health Insurance

You and your family may still be eligible even if you have other health insurance.

1. Does anyone who is applying have Medicare? ☐ No ☒ Yes **If yes, include a copy of your card (red, white and blue card), for each Medicare beneficiary.** SEND PROOF **Complete the rest of this application and complete Supplement A.**

2. Does anyone who is applying already have other commercial health insurance, including long term care insurance? ☐ No ☐ Yes **If yes, you must send a copy of the front and back of the insurance card with this application.** SEND PROOF

Name of Insured (primary) AARP Supple. Ins. Persons Covered JANE DOE Cost of Policy $250/mth End date of cove

Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do NOT need to complete Supplement A. EPIC $80/year

3. Is the parent/step-parent of any child applying a public employee who can get family coverage through a state health benefits plan? (see instructions) ☒ No ☐ Yes
If yes, does the public agency where that person works pay all or part of the cost of the health plan? ☐ No ☐ Yes

4. In the past 6 months, has anyone lost or cancelled any type of health insurance that was provided through an employer? ☒ No ☐ Yes (If no, skip to question 5) If yes, what date di

Your answer to this question will help us understand why people change their health insurance.
Why do the person(s) no longer have the health insurance? (Check only one)

- ☐ 1. The person who had the insurance no longer works for the employer that provided the insurance.
- ☐ 2. The employer stopped offering health insurance.
- ☐ 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent.
- ☐ 4. The cost of health insurance went up and it was no longer affordable.
- ☐ 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have.
- ☐ 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have.

5. Does your current job offer health insurance? **We may be able to help pay for it.** ☐ No ☐ Yes If yes, a "Request for Information Employer Sponsored Health Insurance" form will be sent to you.

N/A - retired

QUESTION 2: If the applicant has a Medicare supplemental insurance, long term care insurance, dental insurance, EPIC, or ADAP, then answer YES.

You should submit proof of all premiums paid for these various policies.

Section E Housing Expenses

1. Monthly housing payment **such as rent or mortgage, including property taxes** (just your share). $ 1400.00

2. If you pay for water separately how much do you pay? $ N/A SEND PROOF How often do you pay? ☐ every month ☐ 2 times a year ☐ quar

3. Do you receive **free** housing as part of your pay? ☒ No ☐ Yes

It is not clear why the application has a question about water, answer the question as best you can.

If you do not pay for water separately, indicate N/A

Section F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for the applicants.

If no one applying is Blind, Disabled, Chronically Ill or in a Nursing Home STOP please go to Section G.

1. Are you, or anyone who lives with you, and is applying, in a residential treatment facility or receiving **nursing home care** in a hospital, nursing home or other medical institution? ☒ No
If yes, finish completing this application **AND** complete Supplement A.

2. Are you or anyone who lives with you blind, disabled or chronically ill? ☐ No ☒ Yes If yes, finish completing this application **AND** complete Supplement A.
Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do not need to complete Supplement A.

THESE QUESTIONS ALSO PERTAIN TO AGED APPLICANTS (65 YRS +). IF THE APPLICANT IS OVER 65, HE/SHE MUST COMPLETE SUPPLEMENT A

Section G Additional Health Questions

If the applicant has EPIC or ADAP, then check Yes to QUESTION 1 and indicate, which program.

TIP: The amount EPIC or ADAP has paid towards the applicant's prescription drug costs in the 3 months prior to the month of application, count as a paid medical expense that can be used as a credit against the applicant's spend down.

1. Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you.
☐ No ☒ Yes If yes: Name: EPIC-for prescriptions In which month(s) of the previous three months do you have medical bills? 2/2010 - 5/2010
SEND PROOF of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? ☐ No ☒ Yes
Unpaid hospital bill from 2006, Balance owed $3000.00

3. Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months? ☒ No ☐ Yes ☐
If yes, who? _____ Which state? _____ Which county? _____

ANSWER YES TO BOTH QUESTIONS 1 & 2., if the Medicaid applicant is requesting retroactive coverage from Medicaid (including for reimbursement purposes) and/ or has paid/unpaid medical bills that he/she wants to submit as a credit against his/her spend down.

4. Does anyone who is applying have a pending lawsuit due to an injury? ☒ No ☐ Yes If yes, who: _____

5. Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)? ☒ No ☐ Yes
If yes, who? _____

Section H Parent or Spouse Not Living in the Household or Deceased

Families who are applying for their children and out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information. If you fear physical or emotional harm as a result of providing information about a parent or spouse not living in the home, you may be excused from providing this information. This is called **Good Cause.** You may be asked to show that you have a good reason for your fears.

1. Is the spouse or parent of anyone applying deceased? ☒ No ☐ Yes
If yes, name of applicant with deceased parent or spouse : _____ (If spouse or parent is deceased go to question 3.)

If the applicant's spouse is deceased, provide his/her information and include a death certificate with the application.

2. Does a parent of any applying child live outside the home? (If no, skip to question 3) ☒ No ☐ Yes

If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box ☐

Child's Name:	Name of parent living outside the home Date of Birth (if known): ___/___/___	Current or last known address: Street: _____ City/State: _____ SSN (if known): _____
Child's Name:	Name of parent living outside the home Date of Birth (if known): ___/___/___	Current or last known address: Street: _____ City/State: _____ SSN (if known): _____

3. Is anyone applying still married to someone who lives outside the home? ☒ No ☐ Yes If yes, name of person applying who is still married: _____

If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box ☐

Legal name of spouse living outside of the home:	Date of Birth (if known):	Current or last known address: Street: _____ City/State: SSN (if known): _____

If the applicant is separated and living apart from his/her spouse, please answer this question.

Section I Health Plan Selection

If you are in receipt of Medicare, STOP skip this section.

If the applicant has Medicare, he/she is EXEMPT from joining Medicaid Managed Care.

If the applicant will have a spend down, he/she is EXCLUDED from joining Medicaid Managed Care.

TIP: Check the small box to the left and write in whether the applicant is exempt or excluded from Medicaid Managed Care.

IMPORTANT: People with Family Health Plus and Child Health Plus **must** choose a health plan to get their health services. Most people with Medicaid **must** choose a health plan; if you don't choose a h enrolled in one unless it is determined you are exempt. **For Medicaid and Family Health Plus:** If you need information about what plans are available in your county, what plans your doctor is in and i **Medicaid CHOICE** at 1-800-505-5678. You can also call or visit your local Department of Social Services. For information about Child Health Plus plans, call 1-800-698-4543. If you already know what plan choice.

NOTE: If you or family members are found eligible for Medicaid, you will be enrolled in the health plan you choose if it provides Medicaid. If you live in a county that does not require people on Medica you do not want to be in a health plan by calling or writing to your local Department of Social Services or by checking this box ☒ Have Medicare & Spend down

Legal Last Name	Legal First Name	Date of Birth	Social Security #	Name of Health Plan You are Enrolling in	Preferred Doctor or Health Center (optional) Check Box if Your Current Provider	OB/GYN (optional)
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	

Section J Signature

I agree to have the information on this application and on the annual renewal shared only among Medicaid, Family Health Plus, Child Health Plus, the health plans indicated in Section I, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Medicaid, Family Health Plus, Child Health Plus, or to evaluate the success of these programs. Each applying adult must sign this application in the space below. By signing this application, I understand that each person applying for Medicaid, Family Health Plus, Child Health Plus, will be enrolled in the appropriate program, if eligible. **I have also read and understand the Terms, Rights and Responsibilities included in this application booklet on the next page.** I certify under penalty of perjury that everything on this application is the truth as best I know.

05/21/2010
Date

Jane Doe
Signature of adult applicant or authorized representative for the applicant

Date

Signature of adult applicant or authorized representative for the applicant

PLEASE MAKE SURE THE APPLICANT(S) SIGNS HERE!!!

REMINDER: If the applicant is disabled, aged, or blind, he/she MUST complete Supplement A.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Family Health Plus, and Child Health Plus. I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid or Family Health Plus, I will tell the social services district. The social services district may be able to help in getting the information.
- If I am applying at a place other than a local department of social services, and my children are not found eligible for Medicaid using this application, I can contact the local department of social services to see if my children are eligible for Medicaid on some other basis.
- I understand that workers from the programs for which family members or I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.
- By applying for Child Health Plus, I agree to pay the applicable premium contribution not paid by New York State.
- I understand that Medicaid, Family Health Plus, and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid or Family Health Plus, I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.
- I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that if my child is on Medicaid or Family Health Plus, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the local department of social services.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

SOCIAL SECURITY NUMBER

Child Health Plus: SSNs are not required to enroll in Child Health Plus. If available, I will include it for children applying for Child Health Plus.

Medicaid, or Family Health Plus: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within department of social services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

FOR MEDICAID APPLICANTS ONLY

- **Release of Educational Records**
  I give permission to the local department of social services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.
- **Early Intervention Program**
  If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local department of social services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

- **Reimbursement of Medical Expenses**
  I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid enrolled providers.

FAMILY HEALTH PLUS AND MEDICAID MANAGED CARE

I understand that in order to receive Family Health Plus benefits, I must join a managed care health plan. I also know that in some counties, joining a health plan may be required to receive Medicaid. I have read how to find out whether my county requires Medicaid enrollees to join a health plan, and how to find out what health plans are available to me in Family Health Plus and in Medicaid managed care. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I/we also understand that if I/we are found eligible for Medicaid instead of Family Health Plus and I/we are in a county that requires Medicaid enrollees to be in a managed care health plan, I/we will be enrolled in the health plan I/we chose unless that health plan does not participate in Medicaid managed care. If I/we are in a county that does not require enrollees to be in a Medicaid managed care health plan, I/we will still be enrolled in the health plan I/we chose unless I/we notify my local social services department in writing, or I/we check the box in Section I, that I/we do not want to be in that plan.

I have read how to find out the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership. I understand that in both Family Health Plus and Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three PCPs in my health plan. I understand that once I enroll in a health plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I understand that if a child is born to me while I am a member of a Medicaid managed care health plan, my child will be enrolled in the same health plan that I am in. I understand that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid managed care, my child will be enrolled in the same health plan that I am in.

- **Release of Medical Information**
  I consent to the release of any medical information about me and any members of my family for whom I can give consent:
  - By my PCP, any other health care provider or the New York State Department of Health (NYSDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
  - By my health plan and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus, and Family Health Plus programs; and
  - By my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations.

I also agree that the information released for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent.

If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

- **Reimbursement of Medical Expenses**
  I understand that if I am determined eligible for Family Health Plus my enrollment will be effective no later than 90 days from the date of submission of a completed application. In the event of an error or delay in my enrollment, Medicaid may be able to reimburse me for reasonable medical expenses I pay as a result of the error or delay. Medicaid may pay my provider for any unpaid expenses only if that provider is a Medicaid enrolled provider.

FOR OFFICE USE ONLY

To be completed by the person assisting with the application

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

To be completed by Facilitated Enrollers

Facilitated Enroller:		Lead Agency/Plan Name:		Lead Org/Plan ID:
Language Used for Application Assistance:	Application Start Date:	Application Sequence Number:	Application Completion Date:	Enter Code of Applying Child: Medicaid _____ CHPlus _____

To be used by the local Social Services District

Eligibility Determined By:	Date:	Eligibility Approved By:		Date:
Center Office:	Application Date:	Unit ID:		Worker ID:
Case Name:	District:	Case Type:		Case #:
Effective Date:	MA Disposition Reason Code: ☐ Denial Code ☐ Withdrawal	Proxy: ☐ Yes ☐ No	Registry #:	Ver:

To be used by Child Health Plus Plans

CHPlus Disposition: ☐ Approved ☐ Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):

Access NY Supplement A

This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care. ☐
  This includes care in a hospital that is equivalent to nursing home care ☐

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

INSTRUCTIONS:

- Sections A through F must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections G through I. ☐

A. This Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Social Security Number	Marital Status
DOE	JANE		123-45-6789	Single

Note: The remaining questions are for the person(s) named above. ☐

THIS INCLUDES AGED APPLICANTS (65 YRS +).

B. Blind, Disabled or Chronically Ill

1. Are you chronically ill?
   (Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)

☒ Yes ☐ No

If the applicant is applying for home care, always check YES.

2. Are you Certified Blind by the Commission for the Blind and Visually Handicapped?
   (If yes, send proof.)

☐ Yes ☒ No

3. If you are disabled and working, are you interested in applying for the MBI-WPD program?

☐ Yes ☒ No

The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

C. Are you living in an adult home or assisted living facility?

☐ Yes ☒ No

D. Resources/Assets (check the box that applies):

☐ You are applying for Medicaid coverage but not coverage of community-based long-term care services. You may attest to the amount of your resources. You are not required to submit documentation of your resources. This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☒ You are applying for coverage of community-based long-term care services documentation of the current amount of your resources.* These services in

ALWAYS CHECK THIS BOX IF APPLICANT IS ALSO APPLYING FOR HOME CARE OR OTHER SERVICES LISTED BELOW.

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

Note: Some examples of home and community-based programs that provide waivers and other services are Traumatic Brain Injury Program and Long Term Home Health Care Program.

☐ You are institutionalized and applying for coverage of nursing home care. You must submit documentation of your resources back to February 1, 2006, or the past 60 months, whichever is less.

* You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

CHECKING/SAVINGS ACCT:
For Community Medicaid, you need to provide documentation that verifies the value of these accounts as of the first of the month in which you are applying. For example, if you are applying for Medicaid in April 2010, then the bank statements must show the balance as of 4/1/2010.

If the client is requesting retroactive coverage (asking Medicaid to pay for medical expenses from the 3 months prior to the month of application), then the applicant also needs to document resources for these months.

List all resources owned by you and/or your spouse/parent(s) **coverage of nursing home care,** also list any accounts closed whichever period is shorter; include balance at closing and pr transferred to or how it was spent. On a separate sheet of pap $2,000 or more. **Note:** Medicaid retains the right to review all tr

1. Checking/Savings/Credit Union Accounts/Certificates of Depo

Bank Name and Account Number	Name of Owner(s)	Amount	Date Closed
Chase-Chk 0000 7654 3217 90	JANE DOE	$ 2000.00	$
Chase-Savings 0000 8693 2478 50	JANE DOE	$ 8000.00	$
Chase-CDs 0000 3461 9853 0	JANE DOE	$ 40,000	$ (Exempt - Restitution)
		$	$
		$	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh):

THIS INCLUDES IRA CDs!

Account Number	Name of Owner(s)	Type/Institution	Cu... Am...	
0000 3247 7e 0145	JANE DOE	Ameritrade	$ 40,000	☒ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

3. Life Insurance Policies:

Insurance Company	Policy Number	Name of Owner(s)	Cash Value	Face Value
MetLife	93431387765R	JANE DOE	$ 3,287.63	$ 10,000

LIFE INSURANCE: If the applicant has a life insurance policy, you MUST include a statement indicating whether the policy has a CASH VALUE, and if it does, the exact amount.

4. Annuities, Stocks, Bonds, Mutual Funds:

Name of Owner(s)	Company		
N/A			$
			$
			$

REMINDER: If the applicant is a Holocaust survivor, is in receipt of reparations, and has resources that are exempt, applicant should disclose these resources, indicate they are exempt, and submit proof with the application.

5. Trust Accounts: If you and/or your spouse created or are the beneficiary of a t including the schedule of trust assets.

Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
N/A			$		$
			$		$
			$		$

6. Burial Assets/Burial Contracts: (Include copies)

Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☒ Yes ☐ No

Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☒ No

Do you and/or your spouse have money in a bank account set aside for a burial fund? ☐ Yes ☒ No

If **yes**, in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		$
		$
		$

Do you have life insurance to be used as your burial fund? ☐ Yes ☒ No

If **yes**, what is your policy number(s)? _____

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

Does your spouse have life insurance to be used as a burial fund? ☐ Yes ☒ No

If **yes**, what is the policy number(s)? _____

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles.

Name of Owner(s)	Year/Make/Model	Fair-Market Value	Amount Owed	In Use?
N/A			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

8. Equity Value in Home:

If you own your home, what is the equity value in your home? $ N/A

Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

This is the information that was previously requested on form MAP-2050J--Home Equity Statement.

9. List Any Other Resources:

Resource Type	Name of Owner(s)	Value
N/A		$
		$
		$
		$
		$
		$

E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply) ☐ Yes ☒ No

☐ Rental Property	☐ Vacation Property	☐ Time Share	☐ Vacant Land	☐ Other Property Rights (In or outside of New York State)

If **yes,** please answer the following questions:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$

F. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☒ No
2. If you are in a medical facility and own your home, do you intend to return to your home? N/A ☐ Yes ☐ No
3. If **no,** is anyone living in the home? ☐ Yes ☐ No

Who is living in the home? _____

How is this person related to you and/or your spouse? _____

If you and/or your spouse's child (of any age) is living in the home, is the child disabled? ☐ Yes ☐ No

Note: If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility.

STOP HERE unless you or anyone in your household is institutionalized and applying for home care. However, the last page of this document MUST be signed.

GO TO PAGE 6. THE APPLICANT DOES NOT NEED TO COMPLETE SECTIONS G, H, & I IF THE APPLICANT IS NOT IN A NURSING HOME!

G. Applicant Living in a Long-Term Care Facility/Nursing Home

Name of Facility	Date Admitted / /	Telephone Number ( )	
Street Address	City	State	Zip
Applicant's Previous Address	City	State	Zip

H. Asset Transfers

1. Transfers

a. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

b. Are you in the process of selling property? ☐ Yes ☐ No

c. Did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No
If **yes,** when? _____

d. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

e. Did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No
If **yes,** when? _____

f. Did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No
If **yes,** when? _____

2. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust? ☐ Yes ☐ No

If you answered yes to any of the questions above, explain the transfer(s) below. Attach additional sheets of paper, if needed.

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			$
			$
			$
			$

3. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? **If yes, send copy of agreement.** ☐ Yes ☐ No

I. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No
If yes, send copies of these returns.

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within the transfer of assets look-back period (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and determined otherwise eligible for Medicaid coverage of nursing facility services, may cause the individual to be ineligible for nursing facility services for a period of time.

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse on or after February 8, 2006, may be treated as a transfer unless:

- The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or
- The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

X Jane Doe
SIGNATURE OF APPLICANT/REPRESENTATIVE

X 5/21/2010
DATE SIGNED

PLEASE MAKE SURE THE APPLICANT(S) SIGNS HERE!!!

X _____
SIGNATURE OF APPLICANT'S SPOUSE

X _____
DATE SIGNED

U.S. Service Center 000
PO Box 769013
San Antonio, TX 78245-9013

000001/R1/20F000
004
CITIBANK, N. A.
Account [redacted]

SAMPLE BANK STATEMENT

Statement Period
July 10 - Aug. 7, 2007

CITIBANK ACCOUNT AS OF AUGUST 7, 2007

NOTE -- Since Statement period does not end on last date of the month, neither opening or closing balance is the amount of resources Medicaid counts for July or August! But can find August amount within statement. See below.

Relationship Summary:

Checking	**$323.19**
Savings	**$1,543.24**
Loans	**$0.00**
Credit Cards	**-----**

Checking	**Balance**
Regular Checking	$323.19

Savings	**Balance**
Insured Money Market	$0.00
e-Savings Account	$1,543.24

Total Value

(as of 7/31/07)

* *Investment Services are provided by Smith Barney, a division and service mark of Citigroup Global Markets Inc., member NYSE/NASD/SIPC. Citigroup Global Markets Inc. and Citibank are affiliated companies under the common control of Citigroup Inc. The summary investment information is for informational purposes only. Review your Smith Barney statement for full transactional detail and other important information.*

INVESTMENT AND INSURANCE PRODUCTS: • NOT FDIC INSURED • NO BANK GUARANTEE • NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY • NOT A BANK DEPOSIT • MAY LOSE VALUE

Total Checking, Savings a

Loans	**Credit Line**	**Amount Available**	**Amount You Owe**
Checking Plus (as of 8/07/07)	$5,600.00	$5,600.00	$0.00

Starting October 1, 2007 Citibank reserves the right to revoke waivers of fees and charges that are not waived pursuant to your account terms and conditions.

SUGGESTIONS AND RECOMMENDATIONS

Take advantage of all Citibank has to offer. You can now choose to receive your statements in Spanish by calling customer service toll-free at 1-800-627-3999. Pay bills, make transfers and view your account activity in Spanish at www.citibank.com/espanol.

CITIBANK ACCOUNT RATES AND CHARGES

When determining your rates and charges for this statement period, Citibank considered your average balances during the month of July in all of your qualifying accounts that you asked us to combine. These balances may be in accounts that are reported on other statements.

Rates and Charges	Your Combined Balance Range $25,000-$49,999
Rates	Preferred
Monthly Service Charge	None

Ask about accounts eligible for preferred rates.

Please refer to your Citibank Account Terms and Conditions for details on how we determine your monthly fees and charges. Please note that when your qualified transaction activity exceeds the designated level, you may be subject to fees for transactions performed.

All fees assessed in a statement period, including per check and non-Citibank ATM fees, will appear as charges on your next Citibank statement (to the account that is currently debited for your monthly service charge).

CHECKING ACTIVITY

Regular Checking
23644626

Beginning Balance: $375.97
Ending Balance: $323.19

Date	Description	Amount Subtracted	Amount Added	Balance
7/12	Authorized Transfer [redacted]		2,104.24	2,480.21
7/13	Authorized Transfer PAYMENT/TRANSFER 010230 BA		50.00	
7/13	Authorized Transfer GEICO PREM COLL	109.30		2,420.91
7/16	Authorized Transfer TRAVELERS INSUR INSURANCE	48.70		2,372.21
7/18	Cash Withdrawal on 07/17[1] at CBC 0030097 164 CANAL STREET, NY, NY	300.00		
7/18	Check # 3757	75.00		1,997.21
7/20	Check # 3761	100.00		1,897.21
7/23				
7/23				2,343.39
7/24	Authorized Transfer CON ED OF NY INTELL CK	114.30		
7/24	Cash Withdrawal at CBC 0010492 401 W 42ND STREET, NY, NY	200.00		2,029.09
7/26	Authorized Transfer [redacted]		2,171.89	4,200.98
7/30	Deposit on 07/29[1] at CBC 0056171 974 THIRD AVE, NY, NY		137.00	
7/30	Cash Withdrawal on 07/29[1] at CBC 0056171 974 THIRD AVE, NY, NY	200.00		4,137.98
7/31	Check # 3758	1,500.00		2,637.98
8/01	Authorized Transfer [redacted]	100.00		2,537.98
8/03	Payment [redacted] REALITY AND ASSOC 010235 DA	710.02		
8/03	Payment [redacted] REALTY ASSOCIATES 010236 DA	100.00		
8/03	Payment [redacted] REALTY ASSOCIATES 010239 DA	25.00		1,702.96
8/06	Authorized Transfer [redacted]	1,329.77		373.19
8/07	Check # 3756	50.00		323.19
	Total Subtracted/Added	**9,515.91**	**9,463.13**	

[1] *Transactions made on weekends, bank holidays or after bank business hours are not reflected in your account until the next business day.*

Resources on August 1st are $2,537.98 - last balance in July

CHECKING ACTIVITY — Continued

Checks Paid

Check	Date	Amount	Check	Date	Amount	Check	Date	Amount	Check	Date	Amount
3756	8/07	50.00	3757	7/18	75.00	3758	7/31	1,500.00	3761*	7/20	100.00

* Indicates gap in check number sequence

Overdraft Protection

As of	Source of Coverage	Amount
8/07	Checking Plus	$5,600
8/07	IMMA	0
8/07	Total Overdraft Protection	$5,600

SAVINGS ACTIVITY

Insured Money Market
52204873

Beginning Balance: $0.00
Ending Balance: $0.00

The balance in your Money Market Account is zero. Please note that if you maintain a zero balance for 90 consecutive days, we will consider the account inactive and will close it. We appreciate your business and we hope you will keep your account open. To do so, simply make a deposit.

e-Savings Account
9977225896

Beginning Balance: $1,737.56
Ending Balance: $1,543.24

Date	Description	Amount Subtracted	Amount Added	Balance
8/06	Cash Withdrawal on 08/05[1] at CBC 0018595 375 COURT ST, BROOKLYN, NY	200.00		1,537.56
8/07	Interest for 29 days, Average Daily Balance $1,716.87 Average Rate 4.16%, Annual Percentage Yield Earned 4.25%		5.68	1,543.24
	Total Subtracted/Added	**200.00**	**5.68**	

[1] *Transactions made on weekends, bank holidays or after bank business hours are not reflected in your account until the next business day.*

CUSTOMER SERVICE INFORMATION

IF YOU HAVE QUESTIONS ON:	YOU CAN CALL:	YOU CAN WRITE:
Checking Checking Plus Insured Money Market	800-627-3999 (For Speech and Hearing Impaired Customers Only TDD: 800-945-0258)	Citibank/Customer Account Services P.O. Box 5870 Grand Central Station New York, NY 10163-5870
Investment Services	800-846-5200 or Call Your Smith Barney Financial Advisor	Smith Barney 111 Wall Street, 3rd Floor New York, NY 10043

This statement does NOT prove amount of resources as of September 1st!