MAIL RENEWAL PROGRAM
HRA/MEDICAL ASSISTANCE PROGRAM
PO BOX 329060
BROOKLYN, NY 11232-9823

NYC Human Resources Administration
Department of Social Services

MAP-909e (E) 12/06/2023

013911 (1:17)

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[redacted]
NEW YORK NY 10004-6006

RENEWAL NOTIFICATION

Medicaid Managed
Long Term Care

LOCATION: CED/MLTC
NOTICE DATE: 03/08/2025
CASE NUMBER: [redacted]
NUMBER OF ADULTS: 01
NUMBER OF CHILDREN: 00
PRIORITY: N
RVI CODE: 2
TELEPHONE NUMBER: [redacted]

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 include all required proofs (explained more below). Return your entire renewal form in the enclosed envelope, **including this page.**

You must return the completed form and proofs **before** 05/10/2025 or your coverage may end**.** If your coverage ends, depending on the coverage that you have now, we will no longer 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, you must 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.

Required Proofs

You **must provide** certain "proofs" supporting the information you provide on this form, such as:

- 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 have a disability, proof of disability-related work (non-medical) expenses, if any, and;
- 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).

Required Proofs – Pooled Trust

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.

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.

If you are married and your spouse is not on Medicaid, we may need to check if there are resources held in your spouse's name that are not in your name. Complete the "Authorization for Verification of Resources (Legal Spouse)" form included in this packet unless you are only applying to renew Medicare Savings Program (MSP). **This form is required to determine your eligibility.**

If you or your representative needs help filling out the form or getting the documents, call the Medicaid helpline at 1-888-692-6116. You can also complete and submit Reasonable Accommodation Request form. A copy of this form has been included in this mailing.

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.

[redacted]

013911 (2:17)

N-03-000256196O8A-20250510-N

1. **HOUSEHOLD INFORMATION:** This section is printed with the names of family members on your case.

- Household Members," "Date of Birth," and "Sex" columns:
  - Update the information if it is wrong or if it has changed.
  - If there is no change in household, check the "No Change" box.
- "Social Security Number" column:
  - 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.
- "Citizenship/Immigration Status" column:
  - 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/X)	Gender Identity* (optional)	Social Security Number	Citizenship/ Immigration Status	No Change
1	[redacted]	[redacted]	M		Number on File		[ ]
2							[ ]
3							[ ]

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth

Gender Identity Codes: M-Male, F-Female, N-Non-Binary or Non-Conforming, X-X, T-Transgender, D-Different Identity: Describe your Identity in space provided

2. ADDRESS (No Proof Required)

Residential Address [redacted] NEW YORK,NY 10009	No Change [ ]
Secondary Address for Notices (if provided) [redacted]	No Change [ ]
Associated Address for Notices (if provided)	No Change [ ]
Housing/Rent Payment_____[redacted]_____ How Often? _____Monthly_____	

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
	[ ]
	[ ]

If you are turning 65 within the next 3 months or you are 65 years of age or older, or, if you have certain disabilities, you are required to apply for Medicare as a condition of eligibility for Medicaid and may be required to submit proof that you have applied for Medicare. For more information, or, to see if you are required to apply, please see enclosed OHIP-0112 YOU MUST APPLY FOR MEDICARE.

4. OTHER HEALTH INSURANCE: You need to answer this question, even if the answer is "no." If the answer is "yes," you should 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
	Social Security Retirement		[redacted]	Monthly	[ ]
	Retirement		[redacted]	Monthly	[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]

6. **RESOURCES**: No Proof Required Unless Indicated Below.
Resources include cash on hand, savings and checking accounts, certificates of deposit ("CDs"), stocks, bonds, trust funds, 401Ks, mutual funds, ownership of a business, property that you or someone in your family owns, etc. **Do not list the home that you live in**.

Complete the tables below and the Authorization for Verification of Resources (Applicant) form included in this packet. **This form is required to determine your eligibility.**

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
Bank Accounts	$8,314.09	[ ]
Bank Accounts	$22.32	[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]

You do not need to send proof of bank accounts at this time. However, if the computer match shows something different than what you reported, you may be asked to provide proof at a later date.

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 $ $1,097,000 ☐ Yes ☐ No

AUTHORIZATION TO VERIFY RESOURCES
YOU MAY SKIP THIS SECTION IF YOU ARE RENEWING MEDICARE SAVINGS PROGRAM COVERAGE ONLY

If my eligibility to renew coverage depends on the amount of my and my spouse's resources (even if my spouse is not receiving/ renewing Medicaid coverage), by signing below we authorize verification of our resources with financial institutions to determine eligibility. **Both spouses must sign below.**

This authorization will end:

- If my application for Medicaid is denied,
- If I am no longer eligible for Medicaid
- If I/we revoke this authorization in a written statement to my local Department of Social Services.

I understand that I will not be asked to prove resources that can be verified electronically, but that I can be asked to prove resources when electronic verification cannot be used.

Fill in the information for a **spouse** who is not applying for/receiving Medicaid:

Last Name	First Name	Middle Initial
Maiden Name or other Name Known By	Social Security Number	Date of Birth

Address is only needed if the address is different from that of the renewing spouse.

House Number	Street Name	Apt Number
City	State	Zip Code

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

If Yes:

Work Related Expense	How Often

10. Vision Disability: (No Proof Required)

We are working to provide our notices to you in the below formats. 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. You can also call us at 1-888-692-6116 for assistance with reading notices that you cannot read.

☐ Large Print
☐ Audio CD
☐ Data CD
☐ Braille

11. Language Preference

The language that I speak is: _____

The language that I read is: _____

Please be sure that you answered all the questions on this form, in all the sections. **Remember to sign Page 8.**

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

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 9 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 the applicant/recipient may have chosen to provide at this time by completing Page 9 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: _____

013911 (5-17)

Financial Maintenance at Renewal

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 your gross, total income (before any deductions) is $1,000 per month and your rent/mortgage is $500 per month, then 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 your gross income is $1,000 per month and your rent/mortgage is $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 $ _____			

Human Resources Administration
Department of Social Services

MAP-3185 (E) 01/09/2025

013911 (6:17)

Act Now! - Medicaid Renewal Rules Have Changed

To renew your Medicaid coverage, you must complete and submit your renewal form by the date listed on your form.

You will lose your Medicaid coverage if you do not return your renewal form by the date requested

Directions for completing your Medicaid renewal:

1. Read your renewal form and attached directions carefully;
2. Complete the Form, making any changes to your household members, the amount of your rent, your insurance premiums, your income, your resources, and any other categories on the form;
3. Include any documents or "proofs" requested on the form; and
4. Return it to the address on the renewal form.

You may call your local department of social services at 888-692-6116 for help with this form.

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.

Authorization for Verification of Resources (Applicant)

Human Resources Administration
Department of Social Services

MAP-3179 (E) (DOH-5148) 04/10/2024

013911 (7-17)

This form authorizes Medicaid to request records from financial institutions for an individual applying for Medicaid.

This Authorization must be signed by the applicant if the applicant is:

- Age 65 or older
- Certified blind or certified disabled (of any age)

Please provide the information for the applicant below and sign the authorization. Signing this Authorization is a condition of receiving Medicaid benefits. This is because eligibility depends on the amount of resources owned by the applicant.

Failure to sign and submit this Authorization may result in a denial or discontinuance of Medicaid benefits.

I. INFORMATION FOR APPLICANT

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth	

II. AUTHORIZATION

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid.

This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I revoke this authorization in a written statement to my local Department of Social Services.

Signature of Applicant /Legal Representative* _____

Date Signed _____

*Note: If a legal representative is signing this authorization, also include the legal document giving their authority to act on behalf of the applicant.

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.

Authorization for Verification of Resources (Legal Spouse)

NYC Human Resources Administration
Department of Social Services

MAP-3179a (E) (DOH-5149) 04/12/2024

013911 (6-17)

This form authorizes Medicaid to request records from financial institutions for the **spouse** of an individual applying for Medicaid.

This Authorization must be signed by the applicant's spouse if the applicant is:

- Age 65 or older
- Certified blind or certified disabled (of any age)

Please complete all sections and sign the authorization.

Signing this Authorization is a condition of receiving Medicaid benefits. This is because eligibility depends on the amount of resources owned by the applicant and the applicant's spouse.

Failure to sign and submit this Authorization may result in a denial or discontinuance of Medicaid benefits.

I. INFORMATION FOR APPLICANT

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth

II. INFORMATION FOR APPLICANT'S SPOUSE

Last Name	First Name	Middle Initial
Maiden Name or other Name Known By	Social Security Number	Date of Birth

Address is only needed if the address is different from that of the renewing spouse.

House Number	Street Name	Apt Number
City	State	Zip Code

III. AUTHORIZATION

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid for my spouse.

This authorization will end if my spouse's application for Medicaid is denied, or my spouse is no longer eligible for Medicaid or, I revoke this authorization in a written statement to my local Department of Social Services.

Signature of Applicant's Spouse/Legal Representative* _____

Date Signed _____

***Note:** If a legal representative is signing this authorization, also include the legal document giving their authority to act on behalf of the spouse.

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.

RENEWAL INSTRUCTIONS

NYC Human Resources Administration
Department of Social Services

MAP-2096p (E) 04/12/2024

013911 (9:17)

Step 1 Answer all questions on the Renewal form (MAP-909e). If the instructions tell you that you must provide proof, see the bottom and the back of this page for a list of what you can use as proof.

Step 2 The **Financial Maintenance at Renewal Form,** on Page 8 of the **Renewal Notification** form (MAP-909e), is only needed if your share of monthly housing expenses is more than 70% of your gross monthly income.

Step 3 If you are enrolled in a Managed Long-Term Care Plan, contact them if you need help to complete your Renewal form.

Step 4 If you have a spouse that is not applying for Medicaid, complete and sign the MAP-3179a (E) Authorization for Verification of Resources (Legal Spouse).

Step 5 Return your completed **Renewal** form, the MAP-3179a E) Authorization for Verification of Resources (Legal Spouse) and proofs to us using the enclosed postage-paid envelope. Please respond before the date printed on Page 1 of the Renewal form (MAP-909e).

Reminder: If you are married, **you and your spouse must** sign Page 7 of the Renewal Notification.

Step 6 If you do not have our envelope, mail the package to:

MAIL RENEWAL PROGRAM
HRA/MEDICAL ASSISTANCE PROGRAM
PO BOX 329060
BROOKLYN, NY 11232-9823

REMEMBER - If you do not follow these instructions, your Medicaid coverage may end.

If you mail your documents to us before the date noted on your Renewal form, your current benefits may continue **unchanged** until further notice.

NOTE:

- You do not need to send proof of income and resources unless the renewal form tells you to do so. The amount of income that you report will be compared to available computer matches. If the results of the computer matches are different than the information you give us, the computer match results will be used when deciding your eligibility. You may send proof of your income and resources to make sure we have the right information. If you choose not to send it now, you may be asked to show proof of your income and/or resources later on. The table on the back of this page shows you what can be used as proof.

- If you just moved from New York City to another county in New York State, but do not have a Medicaid case opened where you live now, you should complete and return the Renewal form (MAP-909e) to us. We will help you in moving your coverage.

INCOME AND RESOURCE DOCUMENTS: All income and resource documents must be current. Do **not** send original documents - only copies.

INCOME: Common types of income and good proofs of that income include the following:

Type of Income	Documentation		Type of Income	Documentation
Earned Income from Employer	Current paycheck/stubs ([4] four consecutive weeks) or letter from employer		Worker's Compensation	Award letter or check stub
Self-Employment Income	Current signed income tax return and all schedules or record of earnings and expenses		Veteran's Benefits	Award letter, benefit check stub, or correspondence from Veterans Administration
Rental/Roomer-Boarder Income	Letter from roomer, boarder, tenant or check stub		Military Pay	Award letter or check stub
Employment Based Sick Pay/Disability Income	Award letter/certificate, benefit check stub, or correspondence from source of income		Interest/Dividends/Royalties	Current statement from bank, credit union, or financial institution, letter from broker, letter from agent, or 1099 or tax return (if no other documentation is available)
Unemployment Benefits	Award letter/certificate, monthly benefit statement, correspondence from the NYS Department of Labor, printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us), or copy of Direct Payment Card with printout		Support from other Family Members	Signed statement or letter from family member
Private Pensions/Annuities	Statement from pension/annuity		Income from a Trust	Trust document
Social Security	Award letter/certificate, annual benefit statement, or correspondence from Social Security Administration		Child Support/Alimony	Letter from person providing support, letter from court, child support/alimony check stub, copy of NY Eppicard with printout, copy of child support account information from www.newyorkchildsupport.com, or copy of bank statement showing direct deposit

EMPLOYMENT: If you are enrolled in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD), you need to show proof of your employment. You can send us one of the following:

Detailed written statement from employer		W-2 form
Current paycheck/stub		Income tax return

RESOURCES: 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.

Acceptable proof of resources include:

Statements/accountings from the financial institutions in which they are held		Real estate appraisals/assessment
Copies of policies/certificates		Promissory note copies

MEDICARE PART C (Medicare Advantage Plan) / Private Heath Insurance: If you receive your Medicare coverage through a Medicare Advantage Plan, you may be entitled to have the cost of your policy premiums deducted from the income that we budget to determine your eligibility/ongoing eligibility. Since plan premiums differ, you must supply proof of your cost.

This income deduction may also apply to you if you pay a health insurance premium to your employer, your union or a third-party insurer.

You can send us one of the following:

Paid invoice		Cancelled check or money order
Copy of bank statement showing payment		Correspondence from insurance provider acknowledging receipt (and dollar amount) of premium payment made
Paystub showing payroll deduction for the cost/your share of the cost for your health coverage,		

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.

HEARING IMPAIRED CONSUMERS WITH TEXT TELEPHONE (TTY) DEVICES MAY CONTACT US AT 718-636-7783 OR BY CALLING 711

Stop Your Medicaid Benefit from Ending

NYC Human Resources Administration Department of Social Services

MAP-3134 (E) 10/01/2020

013911 (12.17)

If you will be turning age 65 in the next three months or have already turned age 65 but are not yet receiving MEDICARE, you may be entitled to additional medical benefits through the MEDICARE program. **In order to continue to be eligible for the Medicaid program, you must apply for and use MEDICARE coverage if it is available to you.**

If you have not already done so, and do not currently have MEDICARE coverage, you **must** apply by calling the Social Security Administration at 1-800-772-1213 or by applying on-line at: https://www.ssa.gov/medicare/. You are eligible to apply when you are within 3 months of turning 65. Proof that you have applied for MEDICARE **must** be included with your Medicaid renewal application.

Proof can be:

- Your award or denial letter from the Social Security Administration, or
- Your online confirmation letter stating that you have applied for MEDICARE with the Social Security Administration

What is the difference between MEDICARE and Medicaid?

- **MEDICARE** is a federal program that gives you health care coverage if you are 65 or older regardless of your income.
- **Medicaid** is a state-run program that covers medical expenses for people with low or limited incomes.

When a person has both MEDICARE and Medicaid, MEDICARE pays first and Medicaid pays second. Individuals with MEDICARE also have more medical providers to choose from.

There are Medicaid programs that may help you with your MEDICARE premiums costs and prescription drugs costs.

- The **MEDICARE Savings Program (MSP)** helps pay the MEDICARE premiums. If you are eligible for the MEDICARE Savings Program, Medicaid will pay the cost of your MEDICARE premiums. This program has higher income levels than Medicaid program and also has no resource test.
- The **MEDICARE Prescription Drug Program (MEDICARE Part D)** is the part of MEDICARE that provides prescription drug coverage. Individuals who have MEDICARE and Medicaid will receive help from Medicaid to pay the Part D premiums.

Apply for MEDICARE Today

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.

PRIVACY NOTICE

Human Resources Administration
Department of Social Services

MAP-2020c (E) 12/21/2023

013911 (14:17)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

The New York Medicaid program must tell you how we use, share, and protect your health information. The New York Medicaid program includes regular Medicaid and Medicaid Managed Care. The program is administered by the New York State Department of Health and the Local Departments of Social Services.

Your Health Information is Private.

We are required to keep your information private, share your information only when we need to, and follow the privacy practices in this notice. We must make special efforts to protect the names of people who get HIV/AIDS or drug and alcohol services.

What Health Information Does the New York Medicaid Program Have?

When you applied for Medicaid, you may have provided us with information about your health. When your doctors, clinics, hospitals, managed care plans and other health care providers send in claims for payment, we also get information about your health, treatments, and medications.

How Does the New York Medicaid Program Use and Share Your Health Information?

We must share your health information when:

- **You or your representative requests your health information.**
- **Government agencies request the information as allowed by law such as audits.**
- **The law requires us to share your information.**

In your Medicaid application, you gave the New York Medicaid Program the right to use and share your health information to pay for your health care and operate the program. For example, we use and share your information to:

- **Pay your doctor, hospital, and/or health care provider bills.**
- **Make sure you receive quality health care and that all the rules and laws have been followed.**

We may review your health information:

- **To determine whether you received the correct medical procedure or health care equipment.**
- **Contact you about important changes in your health benefits.**
- **Make sure you are enrolled in the right health program.**

- **Collect payment from other insurance companies.**
- **To determine eligibility in Medicare Part D or other insurance programs that might be more economical to you.**

We may also use and share your health information under limited circumstances to:

- **Study health care.** We may look at the health information of many consumers to find ways to provide better health care.
- **Prevent or respond to serious health or safety problems for you or your community as allowed by federal and state law.**

Your written authorization is required for other uses and disclosures:

- **Psychotherapy notes**
- **Uses and disclosures of Protected Health Information for marketing purposes, including subsidized treatment communications**
- **Disclosures that constitute a sale of your Protected Health Information.**

We must have your written permission to use or share your health information for any purpose not mentioned in this notice unless we are required to do so by the laws that apply to us.

What Are Your Rights?

You or your representatives have the right to:

- Get a paper copy of this notice.
- See or get a copy of your health information. If your request is denied, you have the right to review the denial.
- Ask to change your health information. We will look at all requests, but cannot change bills sent by your doctor, clinic, hospital or other health care provider.
- Ask to limit how we use and share your information. We will look at all requests, but do not have to agree to what you ask except where required by law to make such a disclosure.
- Ask us to contact you regarding your health care information in different ways (for example, you can ask us to send your mail to a different address).
- Ask for special forms that you sign permitting us to share your health information with whomever you choose. You can take back your permission at any time, as long as the information has not already been shared.
- Get a list of those who received your health information. This list will not include health information requested by you or your representative, information used to operate the New York Medicaid Program or information given out for law enforcement purposes.
- Be notified upon a breach of any of your unsecured Protected Health Information.

See the New York City Human Resources Administration web site for an electronic copy of this notice (https://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/privacy_notice.pdf). You may also visit the New York State Department of Health web site to see an alternate version (https://www.health.ny.gov/health_care/medicaid/program/hipaa/notepriveng.htm).

***You will not be penalized for filing a complaint. If we change the information in this notice, we will post the amended version on our website at:**

(https://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/privacy_notice.pdf)

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.

TERMS, RIGHTS AND RESPONSIBILITIES (Renewal)

Human Resources Administration
Department of Social Services

MAP-3015a (E) 12/05/2023

013911 (16.17)

By completing and signing this form, I am applying to renew Medicaid / Managed Long Term Care / Medicare Savings Program (MSP / QMB) and/or Family Planning Benefit Program coverage.

I understand that I must provide the information needed to prove my eligibility for each program. I agree to immediately report any changes to the information on this form. If I am unable to get the information, I will tell the social services district. The social services district may be able to help in getting the information.

I understand that workers from the programs for which family members or I are renewing may check the information given by me on this form. 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.

I understand that Medicaid and/or Family Planning Benefit Program coverage will not pay medical expenses that insurance or another person is supposed to pay, and that 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 disability or citizenship status may be a factor in whether or not I am eligible.

I understand that if my child is on Medicaid, they can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program.

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.

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS I certify under penalty of perjury, by signing my name on this form, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. The term "satisfactory immigration status" means an immigration status that does not make the person ineligible for benefits. **Important Information**: The United States Citizenship and Immigration Services (USCIS) has said that enrollment in Medicaid CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member or travel in and out of the country (except if Medicaid pays for long term care in a place like a nursing home or psychiatric hospital). **The State will not report any information on this application to the USCIS.**

SOCIAL SECURITY NUMBER All applicants must provide a social security number or proof that they have applied for one or tried to apply for one. The only exceptions are pregnant individuals, undocumented immigrants and temporary non-immigrants applying for the treatment of an emergency medical condition, and certain battered immigrants. SSNs are not required for members of an applicant's household who are not applying for benefits unless this person is the spouse and the applicant's eligibility depends on the amount of resources owned by the spouse. Such disclosure 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, to see if applicants can get money or other help, and to verify resources with financial institutions for recipients and their non-applying spouse. 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.

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 Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) 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; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid; 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 may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

MEDICAID MANAGED CARE If I am adding a family member to a Medicaid case and I live in a county that requires Medicaid recipients to join a health plan, I understand that this family member will be enrolled in the same health plan as my family, unless they are exempt or excluded.

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.

I consent to sharing this information with any school-based health center that provides services to the applicant(s).

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 5039 NEW YORK NY

POSTAGE WILL BE PAID BY ADDRESSEE

MAIL RENEWAL PROGRAM
HRA/MEDICAL ASSISTANCE PROGRAM
PO BOX 329060
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