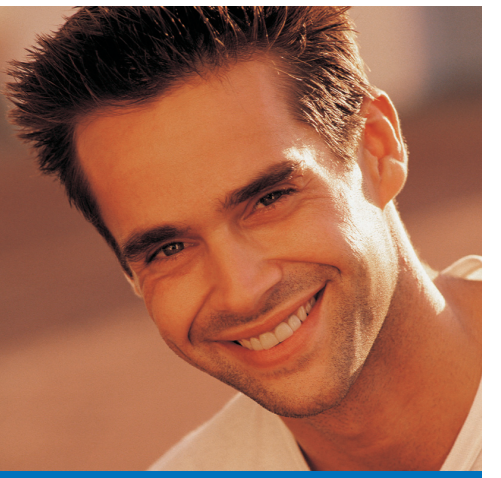

Health Insurance APPLICATION

access NY health care

for Children, Adults and Families

INSTRUCTIONS

CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the Facilitated Enrollers and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.

PURPOSE OF THIS APPLICATION Complete this application if you want health insurance to cover medical expenses. This application can be used to apply for Medicaid, the Family Planning Benefit Program, or for assistance paying your health insurance premiums. You can apply for yourself and/or immediate family members living with you.

IF YOU NEED HELP COMPLETING THIS APPLICATION DUE TO A DISABILITY, CALL YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES. THEY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATIONS TO ADDRESS YOUR NEEDS.

PLEASE READ the entire application booklet before you begin to fill out the application. If you are applying ONLY for children or if you are a pregnant woman applying alone, you must complete only **Sections A through G and Sections I and J.** Other applicants must complete all sections.

If you are 65 years old or older, certified blind, certified disabled, or institutionalized and applying for coverage of nursing home care, you must **also complete Supplement A.** The supplement includes questions about your resources, such as money in the bank or property you own.

Whenever you see the words **SEND PROOF** on the application refer to the "Documentation Needed When You Apply for Health Insurance" section for a listing of acceptable supporting documents.

HOW TO GET HELP When applying for public health insurance, you **DO NOT** need to visit your local department of social services or a Facilitated Enroller for an interview, but you **MAY** come in or contact a Facilitated Enroller for help filling out this application. **You can get a list of Facilitated Enrollers where you got this application, or by calling 1-800-698-4543. ALL HELP IS FREE.**
(1-877-898-5849 TTY line for the hearing impaired)

SECTION A | Applicant's Information

We need to be able to contact the people applying for health insurance. The home address is where the people applying for health insurance live. The mailing address, if different, is where you want us to send health insurance cards and notices about your case. You can also tell us if you want someone else to get information about your case and/or to be able to discuss your case.

SECTION B | Household Information

Please include information for everyone who lives with you even if they are not applying for health insurance. It is important that you list everyone who lives with you so that we can make a correct eligibility decision. Include maiden name (legal name before marriage), if this applies to the person. Also include City, State and Country of birth. If a person was born outside of the United States, just write the country of birth. We also need, for each person applying, his/her mother's full maiden name (first and last name). This information may be used to obtain proof of the applicant's birth date under certain circumstances.

- **Is this person pregnant?** If so, when is her baby due to be born? This information helps us determine the size of your family. A pregnant woman counts as two people.
- **Relationship to the person on Line 1.** Explain how each person is related to the person listed on Line 1 (for example, spouse, child, step-child, brother, sister, niece, nephew, etc.)
- **Public Health Coverage.** If you or anyone who lives with you is already enrolled or was previously enrolled in Medicaid, the Family Planning Benefit Program, or any other form of public assistance such as Food Stamps, we need to know. Also, tell us the identification number on the New York State Benefit Identification Card.
- **Social Security Number.** A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank.
- **Citizenship and Immigration Status.** This information is needed only for those people applying for health insurance. Pregnant women do not have to complete this question. To be eligible for health insurance, other persons age 19 and over must be U.S. citizens or be in an eligible immigration category. We need to see either original documentation of U.S. citizenship and identity, or copies of these documents. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring these documents. Please note that if you are on Medicare, or receiving Social Security Disability but are not yet eligible for Medicare, it is not necessary to document citizenship or identity.

PUBLIC CHARGE INFORMATION

The United States Citizenship and Immigration Services (USCIS) has stated that enrollment in Medicaid, or the Family Planning Benefit Program 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. This is not true if Medicaid pays for long-term care in a place such as a nursing home or psychiatric hospital.

The State will not report any information on this application to the USCIS.

- **Race/Ethnic Group.** This information is optional and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race or ethnic background. You may pick more than one.

SECTION C Household Income (Money Received)

- In this section, list all types of income (money received) and the amounts received by the people you listed in Section B.
- Please tell us how much you make before taxes are taken out.
- If there is no money coming into your home, explain how you are paying for your living expenses, such as food and housing.
- We need to know if you have changed jobs or if you are a student.
- We also need to know if you pay another person or place, such as a day care center, to take care of your children or disabled spouse or parent while you are working or going to school. If you do, we need to know how much you pay. We may be able to deduct some of the amount that you pay for these costs from the amount we count as your income.

SECTION D Health Insurance

It is important to tell us whether anyone applying is covered or could be covered by someone else's health insurance. This information may affect their eligibility for coverage; for some applicants, we can deduct the amount that you pay for health insurance from the amount we count as your income; or we may be able to pay the cost of your health insurance premium if we determine it is cost effective. We may be able to help pay for health insurance premiums if you have or can get insurance through your job. We will need to gather more information about the insurance and will mail an insurance questionnaire to you.

SECTION E Housing Expenses

Write in your monthly cost of housing. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes in the amount you tell us. If you share your housing expenses or your rent is subsidized, please only tell us how much YOU pay toward your rent or mortgage. If you pay for your water, tell us how much you pay and how often.

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

These questions help us determine which program is best for each applicant, and what services may be needed. A person with a disability, serious illness or high medical bills may be able to get more health services. You may have a disability if your daily activities are limited because of an illness or condition that has lasted or is expected to last for at least 12 months. If you are blind, disabled, chronically ill or need nursing home care, you will need to complete Supplement A. If neither you nor anyone applying is blind, disabled, chronically ill or in a nursing home, go to Section G.

SECTION G Additional Health Questions

If you have paid or unpaid medical bills from the past three months, Medicaid may be able to pay for these costs. Let us know who these bills are for and in which months. Include copies of the medical bills with this application. Note: This three-month period begins when the local department of social services receives your application or when you meet with a Facilitated Enroller. You will need to tell us what your income was for any past months in which you have medical bills so that we can see if you are eligible during that time. We also ask about where you lived in the past three months, because this may affect our ability to pay for past bills. We ask about any pending lawsuits or health issues caused by someone else so we know if someone else should pay for any portion of your medical care costs.

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

- **If any applicants have an absent spouse or parent, you must complete this section so we can see if medical support is available to you or your child.**
- **Pregnant women do not have to answer these questions until 60 days after the birth of their child.** 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 the home to be eligible for health insurance, unless there is good cause. An example of "good cause" is fear of physical or emotional harm to you or a family member. Question 2 refers to the **PARENT** of any applying child under age 21. Question 3 refers to the **SPOUSE** of anyone applying.
- If the parents are not willing to provide this information, the applying child may still be eligible for Medicaid.

SECTION I Health Plan Selection

What is a Health Plan? Applying for programs through Access NY Health Care may mean you get your health care coverage through a Managed Care plan. When you join a plan, you choose one doctor (Primary Care Provider or PCP) from that plan to take care of your regular needs. If you want to keep the doctor you have, you need to pick the plan that works with your doctor. Managed Care health plans focus on preventive care so small problems do not become big ones. If you need a specialist, your PCP will refer you to one.

Who Must Choose a Health Plan? MOST people who are eligible for Medicaid **MUST** choose a health plan to get most of their Medicaid benefits. Keep reading to find out how to get more information on this.

How Do I Know What Health Plan to Choose and If I Can Enroll? For Medicaid, if you want to find out more about how managed care plans work, if you have to join, and how to choose a plan, call **Medicaid CHOICE** at **1-800-505-5678,** or call or visit your local department of social services. Ask for a Managed Care Education Packet. Information about health plans is also on the NYSDOH website at **www.nyhealth.gov.** You can also enroll by phone, by calling **1-800-505-5678.**

NOTE: If you or a family member are found eligible for Medicaid, and are in a county that does not require people on Medicaid to join a health plan, you will still be enrolled in the health plan you choose if it provides Medicaid, unless you check the box on the application that says you don't want to be enrolled, or tell us you do not want to be enrolled by calling or writing to your local department of social services.

SECTION J Signature

Please read the paragraph in this section carefully and read the **Terms, Rights and Responsibilities** section. You must then sign and date the application.

NEW YORK STATE | Department of Health

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

Applicant Name _____ **Application Date** _____

*** Your enrollment cannot be completed until all NECESSARY items are received.** ***If you need help getting any of these items, let us know.***

YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS. We only need documents that apply to you or others who are applying. We will need to see copies of documents for identity and U.S. citizenship. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring identity and U.S. citizenship documents. Many local departments of social services do not accept original documents by mail, so please check with them if you wish to mail these documents. Copies of other documents can be mailed with your application.

You need to provide proof of Identity, U.S. Citizenship and/or Immigration Status and Date of Birth.

You can provide ONE of the following documents to prove both U.S. Citizenship, Identity and your Date of Birth:

- ☐ U.S. passport book/card **OR**
- ☐ Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- ☐ Certificate of U.S Citizenship (DHS Forms N-560 or N-561) **OR**
- ☐ NYS Enhanced Driver's License (EDL).

When one of the above documents is not available, ONE document from EACH of the lists below may be used to prove your citizenship and/or identity.
This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

Documents with * next to it also show date of birth

U.S. Citizenship

- ☐ U.S. Birth Certificate*
- ☐ Certification of Birth issued by Department of State (Forms FS-545 or DS-1350)*
- ☐ Report of Birth Abroad (FS-240)
- ☐ U.S. National ID card (Form I-197 or I-179)
- ☐ Native American Tribal Document*
- ☐ Religious/School Records*
- ☐ Military record of service showing U.S. place of birth
- ☐ Final adoption decree
- ☐ Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000

Identity

- ☐ State Driver's license or ID card with photo*
- ☐ ID card issued by a federal, state, or local government agency
- ☐ U.S. Military card or draft record or U.S Coast Guard Merchant Mariner Card
- ☐ School ID card with a photo (may also show date of birth)
- ☐ Certificate of Degree of Indian blood or other Native American/Alaska Native tribal document with photo
- ☐ Verified School, Nursery or Daycare records (for children under 18) (may also show date of birth)
- ☐ Clinic, Doctor or Hospital records (for children under 18)*

If you do not use one of the documents that show date of birth, you must also submit one of the following:

- ☐ Marriage certificate
- ☐ NYS Benefit Identification Card

***Please return all necessary items by:** _____ **or application may be denied.**

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you are not a U.S. Citizen

The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status. This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

We need to see **ONE** of the following documents to prove both Immigration Status, Identity and your Date of Birth:
Documents with * next to it also show date of birth

Immigration Status/Identity

- ☐ I-551 Permanent Resident Card ("Green Card")*
- ☐ I-688B or I-766 Employment Authorization Card*

Immigration Status, but require an additional Identity document

- ☐ I-94 Arrival/Departure Record*
- ☐ USCIS Form I-797 Notice of Action
- ☐ Evidence of Continuous U.S. Residence prior to January 1, 1972

Home Address: This address must match the home address that you write in Section A of the application. The proof must be dated within 6 months of when you signed the application.

- ☐ Lease/ letter/ rent receipt with your home address from landlord
- ☐ Utility Bill (gas, electric, phone, cable, fuel or water)
- ☐ Property tax records or mortgage statement
- ☐ Driver's license (if issued in the past 6 months)
- ☐ Government ID card with address
- ☐ Postmarked envelope or post card (cannot use if sent to a P.O. Box)

PROOF OF CURRENT INCOME, OR INCOME YOU MIGHT GET IN THE FUTURE LIKE UNEMPLOYMENT BENEFITS OR A LAWSUIT: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS, only the ones that apply to you and the people living with you. One proof for each type of income you have is required. Provide the most recent proof of income before taxes and any other deductions. The proof must be dated, include the employee's name and show gross income for the pay period. The proof must be for the last four weeks, whether you get paid weekly, bi-weekly, or monthly. It is important that these be current.

Wages and Salary

- ☐ Paycheck stubs
- ☐ Letter from employer on company letterhead, signed and dated
- ☐ Current signed and dated income tax return and all Schedules**
- ☐ Business/payroll records

Self-Employment

- ☐ Current signed and dated income tax return and all Schedules**
- ☐ Records of earnings and expenses/business records

Unemployment Benefits

- ☐ Award letter/certificate
- ☐ Monthly benefit statement from NYS Department of Labor
- ☐ Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us)
- ☐ Copy of Direct Payment Card with printout
- ☐ Correspondence from the NYS Department of Labor

Private Pensions/Annuities

- ☐ Statement from pension/annuity

***Income tax returns for other than self-employed may be used for applications prior to April 1 of the following year.*

Social Security

- ☐ Award letter/certificate
- ☐ Annual benefit statement
- ☐ Correspondence from Social Security Administration

Workers' Compensation

- ☐ Award letter
- ☐ Check stub

Child Support/Alimony

- ☐ Letter from person providing support
- ☐ Letter from court
- ☐ Child support/alimony check stub
- ☐ Copy of NY Epicard with printout
- ☐ Copy of child support account information from **www.newyorkchildsupport.com**
- ☐ Copy of bank statement showing direct deposit

Veterans' Benefits

- ☐ Award letter
- ☐ Benefit check stub
- ☐ Correspondence from Veterans Affairs

Military Pay

- ☐ Award letter
- ☐ Check stub

Income from Rent or Room/Board

- ☐ Letter from roomer, boarder, tenant
- ☐ Check stub

Interest/Dividends/Royalties

- ☐ Recent statement from bank, credit union or financial institution
- ☐ Letter from broker
- ☐ Letter from agent
- ☐ 1099 or tax return (if no other documentation is available)

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you pay to have care for your children or parents while you work, provide one of the following:

- ☐ Written statement from day care center or other child/adult care provider
- ☐ Canceled checks or receipts that show your payments

Proof of health insurance, provide all that apply:

- ☐ Proof of current insurance (Insurance policy, Certificate of Insurance or Insurance Card)
- ☐ Health Insurance Termination Letter
- ☐ Medicare Card (Red, White and Blue Card)

If you have medical bills in the last three months, provide all the following:

For determination of eligibility for medical expenses from the past three months:

- ☐ Proof of income for the month(s) in which the expense was incurred
- ☐ Proof of residency/home address for the month(s) in which the expense was incurred
- ☐ Medical bills for last three months, whether or not you paid them

Resources (only if you are over 65 or disabled and have no children under 21 living with you):

- ☐ Bank account statements: checking, savings, retirement (IRA and Keogh)
- ☐ Stocks, bonds, certificates statements
- ☐ Copy of Life Insurance policy
- ☐ Copy of burial trust or fund burial plot deed or funeral agreement
- ☐ Deed for real estate other than residence

Proof of Student Status for college students if employed:

- ☐ Copy of schedule
- ☐ Statement from college or university
- ☐ Other correspondence from college showing student status

ACCESS NY HEALTH CARE Medicaid

Print clearly in blue or black ink. An incomplete application cannot be processed and will result in a delay of a decision on your application.

SECTION A Applicant's Information

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

Legal First Name	Middle Initial	Legal Last Name

Primary Phone # ☐ Home ☐ Cell ☐ Work ☐ Other

Another Phone # ☐ Home ☐ Cell ☐ Work ☐ Other

What Language Do You: Speak? _____ Read? _____

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

☐ Check here if homeless

Street | Apt.# | City | State | Zip Code | County

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

Street | Apt.# | City | State | Zip Code

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 | Street | Apt.# | City | State | Zip Code | Phone # ☐ Home ☐ Cell ☐ Work ☐ Other

SECTION B Household Information

If you live in the household, start with yourself. If you do not, start with any adults who live in the household. List the full legal names of the persons applying for or already receiving Medicaid **and list the ID Number from their Benefit Card or health plan ID card.** You **must** provide information for household members including: parents, step-parents, and spouses. You may provide information for other household members (for example, a dependent child under the age of 21). **Listing other household members may allow us to give you a higher eligibility level. Pregnant women and children under 19 may be eligible for health insurance regardless of immigration status.**

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant?	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	_____ 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	SELF	☐ 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	
02	_____ 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		☐ 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	

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 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 Hawaiian or other Pacific Islander, W-White, U-Unknown. Please also tell us if you are Hispanic or Latino-H

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?	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		☐ 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		☐ 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		☐ 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		☐ 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		☐ 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	

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

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 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 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? (weekly, monthly)

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? (weekly, 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 no contributions: ☐

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

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)

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)

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)

6. If you are not eligible for Medicaid 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

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) _____ Persons Covered _____ Cost of Policy _____

End date of coverage, if ending soon _____/_____/_____
Month Day Year

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

3. 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.

SECTION E | Housing Expenses

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

2. If you pay for water separately how much do you pay? $_____ SEND PROOF How often do you pay? ☐ every month ☐ 2 times a year ☐ quarterly (4 times a year) ☐ once a year

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

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 ☐ Yes
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.

SECTION G | Additional Health Questions

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: _____ In which month(s) of the previous three months do you have medical bills? _____

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 proof of payment.**

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? ☐ No ☐ Yes

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? _____

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 pregnant women are **NOT** required to fill 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 the home to be eligible for health insurance, 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.)

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

SECTION I Health Plan Selection

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

IMPORTANT: Most people with Medicaid **must** choose a health plan; if you don't choose a health plan you may be automatically enrolled in one unless it is determined you are exempt. If you need information about what plans are available in your county, what plans your doctor is in and if you have to join, please call **New York Medicaid CHOICE** at 1-800-505-5678. You can also call or visit your local Department of Social Services. If you already know what plan you want, use this section for your 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 Medicaid to join a health plan, you can tell us 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 ☐

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, 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, or to evaluate the success of these programs. Each applying adult must sign this application in the space below. **I have 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.

_____ _____

Date *Signature of adult applicant or authorized representative for the applicant*

_____ _____

Date *Signature of adult applicant or authorized representative for the applicant*

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid. 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, 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.
- I understand that Medicaid, will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid, 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 Medicaid will not be affected by my race, color, or national origin. I also understand that depending on the requirements of the program, 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, 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

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 unless the person is my spouse and my eligibility depends on the amount of resources owned by my spouse. 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, to see if applicants can get money or other help, and to verify resources with financial institutions for applicants 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. 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.

MEDICAID MANAGED CARE

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 Medicaid managed care. I/we also understand that if I/we are found eligible for Medicaid 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.

TERMS, RIGHTS AND RESPONSIBILITIES

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 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 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 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 Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

FOR OFFICE USE ONLY

To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information:	Employed By: (check one) ☐ Health Plan ☐ Social Services District ☐ Provider Agency ☐ Qualified Entities
X_____	Employer Name: _____

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:

Supplement A

(Supplement to Access NY Health Care Application DOH-4220)

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 E 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 F through G.

A. Applicant and Spouse Information

1. Applicant(s) this Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Marital Status	Social Security Number	Date of Birth	If Deceased, List Date of Death
					/ /	/ /
					/ /	/ /

Is a person named above:

- Chronically ill? ☐ Yes ☐ No
  (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.)

- Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
  (If yes, send proof.)

- Interested in applying for the MBI-WPD program if disabled and working? ☐ Yes ☐ No
  The Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program 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.

If an applicant is living in a long-term care facility/nursing home, adult home, or assisted living facility, provide the following information.

Name of Applicant who is in Facility	Name of Facility	Date Admitted / /	Telephone Number ( ) -
Street Address	City	State	Zip Code
Applicant's Previous Address	City	State	Zip Code

If the above previous address was also a facility or adult home, list the address prior to admission below.

Applicant's Second Previous Address	City	State	Zip Code

2. Applicant's Spouse: (if not listed above)

Legal Last Name	Legal First Name	MI
Maiden Name or Other Name Known By:	Social Security Number	Date of Birth / /
Street Address (if in a facility, list spouse's address prior to being admitted to facility)		
City	State	Zip Code

Is the applicant's spouse living in a long-term care facility/nursing home? ☐ Yes ☐ No

If **yes**, provide the following information:

Name of Facility	Date Admitted / /	Telephone Number ( ) -

Street Address	City	State	Zip Code

Is the applicant's spouse deceased? ☐ Yes ☐ No If **yes**, what is the date of death? _____ / _____ / _____

B. What Care and Services are you Applying for? (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 at this time. If a computer match shows something different than what you reported, you may be asked to submit proof at a later date.

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 is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

This coverage includes the following services:*

- 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 waiver and other services are Traumatic Brain Injury Program and Nursing Home Transition and Diversion Program.

☐ **You are institutionalized and applying for coverage of nursing home care.** Documentation of your resources for the **past 60 months** is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

*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.

DOCUMENTATION REQUIREMENTS

If you are requesting coverage for **community-based long-term care services** or **nursing home care,** provide documentation for the time period indicated above for all of the following resources, if applicable.

- Life insurance policy;
- Securities, stocks, bonds, and mutual funds;
- Annuities;
- Burial agreement or fund;
- Trust document and accounts.

You do not need to send proof of any other resources at this time. This is because other resources may be verified through computer matches. If the resources you report do not match our records or cannot be verified through our records, we may ask you to submit proof of those other resources at a later date.

C. Resources/Assets

INSTRUCTIONS FOR SECTIONS 1 THROUGH 8:

- List all resources currently owned by you and/or your spouse/parent(s), including custodial accounts.
- Check the **"NONE"** box if you and/or your spouse/parent(s) do not own any of those resources.
- **If applying for coverage of nursing home care,** also list any accounts CLOSED in the **past 60 months;** include the balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more.
  Note: Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs): ☐ NONE

Bank Name	Account Number	Name of Owner(s)	Current Account Balance	Closed Accounts	
				Date Closed	Balance at Closing
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh): ☐ NONE

Institution Name	Account Number	Name of Owner(s)	Pay Out	Current Account Balance	Closed Accounts	
					Date Closed	Balance at Closing
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$

3. Annuities, Stocks, Bonds, Mutual Funds: ☐ NONE

Institution/Company Name	Account Number	Name of Owner(s)	Date Purchased	Current Value	Closed Accounts	
					Date Closed or Sold	Value at Closing
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$

4. Life Insurance Policies: ☐ NONE

Insurance Company	Policy Number	Name of Owner(s)	Current Cash Value	Current Face Value	Cancelled Policies	
					Date Cancelled	Cash Out Value
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$

5. Burial Assets/Burial Contracts: (Include copies): ☐ NONE

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

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

c. 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
		$
		$
		$

d. 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

e. 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

6. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the current schedule of trust assets. ☐ NONE

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

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles. ☐ NONE

Name of Owner(s)	Year/Make/Model	Fair Market Value	Amount Owed	In use?	Date Sold
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /

8. List Any Other Resources:

Resource Type	Name of Owner(s)	Value
		$
		$
		$
		$
		$
		$

D. 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? ☐ Yes ☐ No

   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. **Send proof of legal impediment.**

3. Equity Value in Home:
   If you own your home, what is the equity value in your home? $ _____
   Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

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**, provide the following information:

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	$

STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, Section I of this document MUST be signed.

F. Asset Transfers

1. Transfers

a. In the last 60 months, 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. 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 either 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
			$
			$
			$
			$

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

d. In the last 60 months, 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? _____

e. 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

f. In the last 60 months, did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No

If **yes,** when? _____

g. In the last 60 months, did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No

If **yes,** when? _____

2. 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? ☐ Yes ☐ No

If yes, send copy of agreement.

G. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No

If yes, send complete copies of these returns including all schedules and attachments.

H. Important Information

Liens on Real Property

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.

Transfer of Assets

Federal and State laws provide that an individual may be found ineligible for nursing facility services for a period of time if an individual or an individual's spouse transfers an asset for less than fair market value within the look-back period. The look-back period is the 60 months immediately prior to the date an individual is both institutionalized and has applied for Medicaid.

Annuities

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 within the look-back period, 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. Certification and Authorization

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.

If eligibility depends on the amount of my and my spouse's resources, by signing this application we authorize verification of our resources with financial institutions for the purpose of determining eligibility. Both spouses must sign below. This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Social Services.

X _____
SIGNATURE OF APPLICANT/REPRESENTATIVE

X _____
DATE SIGNED

X _____
SIGNATURE OF APPLICANT'S SPOUSE

X _____
DATE SIGNED

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

Your enrollment cannot be completed until all NECESSARY items are received. ***If you need help getting any of these items, let us know.***

YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS. We only need documents that apply to you or others who are applying. We will need to see original or certified copies of documents for identity and U.S. citizenship. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring identity and U.S. citizenship documents. Many local departments of social services and Child Health Plus health plans do not accept original documents by mail, so please check with them if you wish to mail these documents. Copies of other documents can be mailed with your application.

You need to provide proof of Identity, U.S. Citizenship and/or Immigration Status and Date of Birth.

Effective 7/1/10, citizen children who provide a social security number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.
You can provide ONE of the following documents to prove both U.S. Citizenship, Identity and your Date of Birth:

- U.S. passport book/card **OR**
- Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- Certificate of U.S Citizenship (DHS Forms N-560 or N-561) **OR**
- NYS Enhanced Driver's License (EDL).

When one of the above documents is not available, ONE document from EACH of the lists below may be used to prove your citizenship and/or identity.
This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.
Documents with * next to it also show date of birth

U.S. Citizenship

- U.S. Birth Certificate*
- Certification of Birth issued by Department of State (Forms FS-545 or DS-1350)*
- Report of Birth Abroad (FS-240)
- U.S. National ID card (Form I-197 or I-179)
- Native American Tribal Document*
- Religious/School Records*
- Military record of service showing U.S. place of birth
- Final adoption decree
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000

Identity

- State Driver's license or ID card with photo*
- ID card issued by a federal, state, or local government agency
- U.S. Military card or draft record or U.S Coast Guard Merchant Mariner Card
- School ID card with a photo (may also show date of birth)
- Certificate of Degree of Indian blood or other Native American/Alaska Native tribal document with photo
- Verified School, Nursery or Daycare records (for children under 16) (may also show date of birth)
- Clinic, Doctor or Hospital records (for children under 16)*

If you do not use one of the documents that show date of birth, you must also submit one of the following:

- Marriage certificate
- NYS Benefit Identification Card

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you are not a U.S. Citizen

The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status. This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

We need to see **ONE** of the following documents to prove both Immigration Status, Identity and your Date of Birth:
Documents with * next to it also show date of birth

Immigration Status/Identity

- I-551 Permanent Resident Card ("Green Card")*
- I-688B or I-766 Employment Authorization Card*

Immigration Status, but require an additional Identity document

- I-94 Arrival/Departure Record*
- USCIS Form I-797 Notice of Action
- Evidence of Continuous U.S. Residence prior to January 1, 1972

Home Address: This address must match the home address that you write in Section A of the application. The proof must be dated within 6 months of when you signed the application.

- Lease/ letter/ rent receipt with your home address from landlord
- Utility Bill (gas, electric, phone, cable, fuel or water)
- Property tax records or mortgage statement
- Driver's license (if issued in the past 6 months)
- Government ID card with address
- Postmarked envelope or post card (cannot use if sent to a P.O. Box)

PROOF OF CURRENT INCOME, OR INCOME YOU MIGHT GET IN THE FUTURE LIKE UNEMPLOYMENT BENEFITS OR A LAWSUIT: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS, only the ones that apply to you and the people living with you. One proof for each type of income you have is required. Provide the most recent proof of income before taxes and any other deductions. The proof must be dated, include the employee's name and show gross income for the pay period. The proof must be for the last four weeks, whether you get paid weekly, bi-weekly, or monthly. It is important that these be current.

Wages and Salary

- Paycheck stubs
- Letter from employer on company letterhead, signed and dated
- Current signed and dated income tax return and all Schedules
- Business/payroll records

Self-Employment

- Current signed and dated income tax return and all Schedules
- Records of earnings and expenses/business records

Unemployment Benefits

- Award letter/certificate
- Monthly benefit statement from NYS Department of Labor
- Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us)
- Copy of Direct Payment Card with printout
- Correspondence from the NYS Department of Labor

Private Pensions/Annuities

- Statement from pension/annuity

Social Security

- Award letter/certificate
- Annual benefit statement
- Correspondence from Social Security Administration

Workers' Compensation

- Award letter
- Check stub

Child Support/Alimony

- Letter from person providing support
- Letter from court
- Child support/alimony check stub
- Copy of NY Epicard with printout
- Copy of child support account information from **www.newyorkchildsupport.com**
- Copy of bank statement showing direct deposit

Veterans' Benefits

- Award letter
- Benefit check stub
- Correspondence from Veterans Affairs

Military Pay

- Award letter
- Check stub

Income from Rent or Room/Board

- Letter from roomer, boarder, tenant
- Check stub

Interest/Dividends/Royalties

- Recent statement from bank, credit union or financial institution
- Letter from broker
- Letter from agent
- 1099 or tax return (if no other documentation is available)

Support from Other Family Members

- Signed statement or letter from family member

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you pay to have care for your children or parents while you work, provide one of the following:

- Written statement from day care center or other child/adult care provider
- Canceled checks or receipts that show your payments

Proof of health insurance, provide all that apply:

- Proof of current insurance (Insurance policy, Certificate of Insurance or Insurance Card)
- Health Insurance Termination Letter
- Medicare Card (Red, White and Blue Card)

Pregnant women only: proof of pregnancy, provide one of the following:

- Presumptive Eligibility Screening Worksheet for pregnant women completed by a qualified provider that tells us the expected date of delivery
- Statement from medical professional (such as a doctor or nurse practitioner) with the expected date of delivery
- WIC Medical Referral Form that tells us the expected date of delivery

If you have medical bills in the last three months, provide all the following:

For determination of eligibility for medical expenses from the past three months:

- Proof of income for the month(s) in which the expense was incurred
- Proof of residency/home address for the month(s) in which the expense was incurred
- Medical bills for last three months, whether or not you paid them

APPLICANT/RECIPIENT DECLARATION CONCERNING THE LEGALLY RESPONSIBLE RELATIVE'S INCOME/RESOURCES

NYC Human Resources Administration Department of Social Services

MAP-2161 (E) 05/11/2018

DATE: _____

CASE NAME: _____

CASE NUMBER: _____

If you have any questions, call HRA Helpline at 888-692-6116

Dear _____

This form is to be completed by the applicant or recipient who is living with a Legally Responsible Relative (LRR) who has refused to make income and/or resources available for the cost of necessary medical care and services. Legally Responsible Relatives are: spouses (e.g. husband for wife, wife for husband) and parents for children under 21.

The Legally Responsible Relative is not absolved from providing financial resources for the care of his or her spouse or child. The Department of Social Services expects the legally responsible relative to cooperate with the process of substantiating the income and resources of the responsible relative in order to determine the amounts the Legally Responsible Relative will be required to pay**. Legally Responsible Relatives may be taken to court for failure to support their spouses or minor children**. Failure to provide requested financial information may also result in the legally responsible relative being taken to court.

Complete the table below, including your signature and the date, and return this entire form in the enclosed envelope within 10 days

I (Print name) _____ _____ declare that my
(First) (Last)

☐ Spouse ☐ Parent ☐ Other, specify: _____
has refused to make his/her income and/or resources available for the cost of necessary medical care and services. I have read the above and understand that the process of financial review and collection of my Medicaid debt from my legally responsible relative begins when I sign this form.

Name of Legally Responsible Relative: _____ _____
(First) (Last)

Social Security Number of Legally Responsible Relative:_____

In consideration of the determination of my eligibility for Medical Assistance, I hereby assign, to the Commissioner of the New York City Human Resources Administration (Department of Social Services), my right of support from the legally responsible relative named above.

Name of Legally Responsible Relative's Health Care Plan (if applicable)

Type of Health Care Coverage (i.e. Long-Term Care): _____

Policy Number (if applicable): _____

Contact Number: ( )_____
(Area Code)

Signature of Applicant/ Recipient: _____ Date: _____

Worker's Name	Title	Section

Supervisor's Name (Print)	Supervisor's Name (Sign)

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

DECLARATION OF THE LEGALLY RESPONSIBLE RELATIVE

Human Resources Administration
Department of Social Services

MAP-2161a (E) 05/11/2018

_____ DATE: _____

_____ CASE NAME: _____

_____ CASE NUMBER: _____

HRA HelpLine: 888-692-6116

Dear _____:

An application/recertification for Medicaid has been submitted by or on behalf of the person named above. You have been identified as the Legally Responsible Relative (LRR).

If found eligible, Medicaid will cover that part of the consumer's care for which s/he is unable to pay because of the refusal of the Legally Responsible Relative to make available income and/or resources for the cost of necessary medical care and services.

Legally Responsible Relatives are: a husband for his wife, a wife for her husband, and parents for children under 21.

IMPORTANT NOTICE: Legally Responsible Relatives may be taken to court for failure to support their spouses or minor children.

Complete the table below, including your signature and the date, and return this entire form in the enclosed envelope within 10 days.

Name: _____ _____
(First) (Last)

Relationship to the Medicaid Applicant/Recipient (check box): ☐ Spouse ☐ Parent ☐ Other: _____
(specify)

Social Security Number: _____ _____

Name of your Health Insurance Plan (if applicable):
_____

Type of Health Insurance Coverage (i.e. Long-Term Care): _____

Policy Number (if applicable):_____

Contact Number: (_____)_____
Area Code

I declare that I refuse to make my income and/or resources available for the cost of necessary medical care and services for the Medicaid applicant/recipient listed above.

Signature of the Legally Responsible Relative: _____ Date:_____

If you have any questions, contact:

SUPERVISOR	SECTION	TELEPHONE NUMBER

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

MEDICAID HOMECARE FACT SHEET

Medicaid base eligibility on two factors: financial and medical. Financial consists of income and assets. As of January 1, 2023 Medicaid has established the following income and assets caps.

Income

For an individual, maximum *monthly income* is **$**1,677 per household for person 65 or older, blind or disabled.

*For a couple, maximum *monthly income* is $2,268 per household for persons 65 or older, blind or disabled. This income limit is only applicable when both spouses need Medicaid homecare.

Assets

Total net assets/resources for individuals cannot exceed **$30,180.** (However you are allowed to transfer assets, see exception below.)

Total net assets/resources* for a couple cannot exceed **$40,820. (However you are allowed to transfer assets, see exception below.) This asset limit is only applicable when both spouses need Medicaid homecare.

Funeral Trust

As of January 1, 1997 Medicaid recipients have the option to prepay certain funeral expenses with an irrevocable funeral trust held by a funeral home. There is no limit on the amount of money that can be placed in the irrevocable funeral trust. Burial funds established prior to 1997 remain in effect. At that time maximum amount permitted was $1,500.

Exceptions to Guidelines

There are exceptions to these income and asset guidelines. A person can qualify for Medicaid even if his or her income and/or assets exceed the above guidelines.

Excess Income Programs (also referred to as "spend down" or "surplus income") – Monthly income can exceed the Medicaid guidelines. Excess income must be paid monthly to the city to contribute towards the cost of home care.

Pooled Income Trusts – A common barrier to applying for Community Medicaid through the Excess Income (also knowns as the "Spend Down" or "surplus income") Program is that the most individuals require most or all their income to pay living expenses, i.e. rent, utilities, etc. These individuals can still be obtain Medicaid benefits AND continue to use most of their income for personal expenses by joining a type of Supplemental Needs Trust known as a Pooled Income Trust.

A Supplemental Needs Trust (SNT) is a legal tool developed to help disabled people keep the income and/or assets they need to live in the community without losing their public benefits. One type of SNT that can help people whose income exceeds the Medicaid eligibility limit is a

Pooled Income Trust (PIT). A PIT is a group account where recipients "pool" their income. Various non-profit organizations administer PITs (see attached list).

When a Medicaid recipient joins a trust, he/she pays her monthly "excess income" into the trust. Money deposited into a PIT is not counted as income by Medicaid. Therefore, when Medicaid approves an individual's participation in the trust, it adjusts the recipient's budget so that he/she no longer "excess income" that must be paid back to the Medicaid program. The Medicaid recipient, or his/her Power of Attorney, then directs the trusts organization to pay necessary bills from the money paid to the trust. Bills that are only for the benefit of the recipients can be paid, and these may include rent, mortgages, maintenance, utility bills, and credit card bills, as long as it makes the payments directly to the landlord or other third party. The trust cannot give money directly to the participant. In this way, the recipient keeps his/her Medicaid benefits, is able to obtain home care, and is able to utilize most of his/her income to pay the bills necessary to stay at home. There are fees associated with participating in a PIT.

To be eligible to participate in a PIT, one must be certified disabled to standards set by the Social Security Administration. If this has not been done at a precious time in the participant's life, then the necessary medical documentation certifying the qualifying disability must be completed. The process of joining a trust varies by organization, but once the trust is joined, the individual must send proof of the trust along with the disability documents to Medicaid (either with the Medicaid application or after the Medicaid application has been submitted) so that Medicaid can certify the disability and approve the trust.

Money paid to the trust on a monthly basis should not be allowed to accumulate. If it does, a participant may be denied Medicaid coverage for nursing home benefits in the future because the accumulation of funds in the trust is viewed as a transfer of assets. In addition, all funds reaming in the trust at the time of the death of the participant become the property of the non-profit organization administering the trust.

Spousal Refusal – Medicaid law assumes the well spouse is legally responsible for the ill spouse. However, by signing "The Declaration of the Legality Responsible Relative" form in which the well spouse refuses to provide financial support to the ill spouse, Medicaid must pay for the ill spouse's care. If such a spousal refusal form is signed, the well spouse's income, which must be disclosed, will not be considered part of the financial review. It must be noted that currently the city is more aggressive in seeking repayment from refusing spouses for Medicaid expenses incurred.

Transfer of Assets – Medicaid currenlty allows transfers for Medicaid home care without penalty, however this will changes sometime in 2023. An elder law attorney should be consulted prior to taking such action.

*Use the income and asset limits for a couple only if both spouses need homecare. If only one spouse needs homecare, use the guidelines for an 'individual'.

List of Pooled SNTs in New York State

This is an unofficial list of non-profit organizations in New York State that offer pooled Supplemental Needs Trusts (or similar services) to people with disabilities. We do not claim that this is an exhaustive list; there may be other pooled trusts in the state of which we are unaware. In addition, the specifics about each trust may not be up to date, so the best source of information is to contact the trust organization directly. Please let us know if you find any corrections. For more information on Pooled Income Trusts, see our fact sheets in English and Spanish.

Name and Contact Info	Comments	Accepts monthly income to eliminate Medicaid spend-down
Adults and Children with Learning & Developmental Disabilities, Inc. (ACLD) 807 South Oyster Bay Road Bethpage, NY 11714 http://www.acld.org/ Colleen Crispino 516-822-0028 x 138 crispinoc@acld.org	Trust A - third-party trust Trust B - self-settled trust	No
AHRC NYC Foundation 83 Maiden Lane New York, NY 10038 (212) 780-2690 Email: info@ahrcnycfoundation.org http://www.ahrcnycfoundation.org/	**Community Trust I for Persons with Disabilities** • Third-party trust • Minimum contribution: $10,000 • Annual fee of <1% **Community Trust II** • Self-settled trust • Minimum contribution: $10,000 • Annual fee of <2%	No

Camphill Resident's Trust 317 Church Street Phoenixville, PA 19460 (610) 291-5079 Email: info@camphilltrust.com http://www.camphilltrust.com/	The minimum for starting a CRT account is $ 15,000. However, an initial deposit of as little as $ 3,000 may open an account with the remainder of the $ 15,000 to be deposited within two years. Additional contributions, in amounts of $ 100 or more, can be made at any time to an established CRT account.	No
Catholic Family Center 30 N. Clinton Avenue Rochester, NY 14604 (585) 232-1840 x4003 / x4022 http://www.cfcrochester.org/	• Formerly Family Service of Rochester • They do not operate a pooled trust, but will serve as trustee for individual SNTs • This might be a good option for individuals under 65 who want to establish an individual SNT, but where the trust corpus is too small to afford a for-profit institutional trustee • They can serve as trustee for lump sums, but also for monthly excess income • The trust agreement must specify that CFC receives the statutory trustee fee • CFC must be contacted by the attorney during drafting of trust • Beneficiaries must have a case manager or other go-between	Yes
Center for Disability Rights, Inc. 497 State Street Rochester, NY 14608 CDR Pooled Trust Info & Forms Amanda Flannery or Mirta Arroyo marroyo@cdrnys.org	• Self-settled trust • No minimum balance • $240 start-up cost (includes $200 enrollment fee plus $20 monthly fee and $20 minimum deposit) • $20 monthly fee (covers up to	Yes

Ph: (585) 546-7510 Fax: (585) 546-7567 / (585) 546-7560	4 disbursements per month; $10 fee for each additional disbursement) • $50 annual accounting fee	
Community Living Corporation (CLC) 600 Bedford Road Mt. Kisco, NY 10549 (914) 241 2076 Email: clcfoundation@optonline.net http://www.clcpooledtrust.org	**Pooled Trust 1** Pooled Trust 1 is a third-party SNT, established with funds provided by a family member or friend. • Minimum Deposit: $10,000 • One-time enrollment fee $200 • $1,000 annual fee for accounts under $25,000 • For accounts over $25,000, annual fee of not less than $1,000 to be negotiated with trustee **Pooled Trust 2** Pooled Trust 2 is a self-settled SNT, established with funds provided by the beneficiary. • Minimum Deposit: $5,000 • One-time enrollment fee $250 • $1,000 annual fee for accounts under $50,000 • For accounts over $50,000, additional annual fee of 1% of balance in excess of $50,000	Yes
Disabled and Alone / Life Services for the Handicapped, Inc. Mailing address: PO Box 340 New Hyde Park, NY 11040-0340 Office Address:	• Third-party trust • Minimum deposit: $100,000 • First-party trust • Minimum deposit $20,000, but annual fee $750 if under $100,000, plus 1% of balance	Yes if have 1st party trust established with minimum deposit

1441 Broadway, 6TH Floor PMB #6135 NY NY 10018-1905 Ph: (212) 532-6740 / (800) 995-0066 Fax: (212) 532-3588 http://www.disabledandalone.org/	for accounts up to $1 Mill, with smaller % for part exceeding $1 Mill., plus co-trustee and tax preparation fees	
Future Care Community Pooled Trust (A partnership of Al Sigl Community of Agencies, Lifespan and the Arc of Monroe) 1000 Elmwood Avenue Rochester, NY 14620 T: 585-402-7840 Ext 2 http://www.futurecareplanning.org/	Must Reside in Monroe County or surrounding counties to be able to join this trust **1st Party Lump Sum Pooled Trust** • $200 enrollment fee • $3000 minimum opening deposit ($2000 if on SSI) • 0.95% annually for investment services • 0.75% annually for administrative fee • $50 annual audit fee • $30.00 per month additional fee if trust is used for monthly disbursements **1st Party Spend Down Pooled Trust** • $200 enrollment fee • $100 Minimum balance • $30 per month includes 4 disbursements ($5 per additional disbursement) • $50 annual audit fee **3rd Party Pooled Trust** • $5000 minimum opening deposit • Please call for fees	Yes (1st Party Spend Down Pooled Trust)
KTS Pooled Trust	• $250 enrollment fee	Yes

3011 Avenue K Brooklyn, NY 11210 Phone: (718) 475-5000 FAX: (718) 475-5010 Email: info@ktstrust.org http://ktstrust.org/	• Monthly fee of 10% of required monthly deposit (minimum $30, maximum $200) • Annual renewal fee of $100 • Monthly contributions can be made by ACH direct debt from bank account • No minimum balance • No minimum funding	
LCG Community Trust LCG Community Services, Inc. 14 Mount Hope Place Bronx, NY 10453-6102 (718) 466-2200 Email: Info@lcgcs.org http://www.lcgcs.org/	**Community Trust I – Self-Directed Asset Trust** • $25,000 minimum contribution within 12 years of enrollment • Enrollment fee of 1% of initial deposit (minimum $250) • Monthly administrative fee of 2% of funds on deposit (minimum $42) • Monthly brokerage fee of 0.042% • Annual renewal fee of $100 • Annual audit and tax return fee of $100 • Can designate remainder beneficiaries to receive no more than 50% of corpus remaining on disabled beneficiary's death **Community Trust II – Third Party Asset Trust** • $25,000 minimum contribution within 12 years of enrollment • $250 enrollment fee • Monthly administrative fee of 2% of funds on deposit (minimum $42) • Monthly brokerage fee of	Yes (Community Trust II and III)

	0.042% • Annual renewal fee of $100 • Annual audit and tax return fee of $100 • Can designate remainder beneficiaries to receive no more than 50% of corpus remaining on disabled beneficiary's death **Community Trust III – Medicaid Spend-Down Trust** • Minimum monthly deposit: $500 • $250 enrollment fee • Monthly administrative fee of 8.5% of required monthly deposit (minimum $42.50) • Annual renewal fee of $100 • Annual audit and tax return fee of $100 • All funds remaining in the trust at beneficiary's death are retained by trustee organization	

Life's WORC Trusts
1501 Franklin Avenue
PO Box 8165
Garden City, NY 11530
516-741-9000 ext. 225
516-348-7878
Fax: (516) 302-1802
Email: trustservices@lifesworc.org
 	
http://www.lifesworctrust.org/
	Self-Settled Trust (Community Trust 1)
	
	• Self-settled trust
	• Minimum deposit: $500
	• One-time non-refundable enrollment fee of $250
	• Annual fees:
	  ◦ Up to $20,000 - 5% of Account Balance;
	  ◦ $20,000 to $50,000 - $1000;
		YES (Community Trust 3 only)

    - $50,000 and above - additional 1% of balance over $50,000
- Annual accounting fee of $100
- At beneficiary's death the balance is retained by the trust

Third-Party Pooled Trust (Community Trust 2)

- Third-party trust
- Minimum deposit: $10,000
- One-time non-refundable enrollment fee of $250
- Annual fees:
    - Up to $20,000 - 5% of Account Balance;
    - $20,000 to $50,000 - $1000;
    - $50,000 and above - additional 1% of balance over $50,000
- Annual accounting fee of $100
- Can designate remainder beneficiary for up to 75% of balance

Surplus Income Pooled Trust (Community Trust 3)

- Excess Income Trust
- Minimum deposit must be maintained in the account: $300
- One-time non-refundable enrollment fee of $250
- Double the monthly deposit is required before expenses can be paid, with one month remaining available for bill pay
- Flat monthly fee ranging

	from $30 - $350 depending upon the monthly spend-down deposit amount. For deposits over $4000 contact Life's WORC to determine the fee. (Surplus-Fee-Schedule.pdf) • Annual accounting fee of $50 **Individual SNT** • $500 non-refundable, one time enrollment fee • Minimum initial deposit $50,000 • Annual Fees: Balances up to $300K; $1,250 plus 1% of balance over $50K	
LIFE, Inc. Pooled Trust (Labor & Industry For Education, Inc.) 112 Spruce St Cedarhurst, NY 11516 Telephone: (516) 374-4564 ext. 3 www.lifetrusts.org	LIFE offers: (i) a self-settled (i.e. established by the beneficiary) monthly spend-down trust (ii) a self-settled asset trust and (iii) third-party asset trusts • $300 one time sign-up fee • $200 annual fee from the second year on • Monthly fee depends on amount of the spend-down (set fee, not percentage) • No minimum deposit • Automated Monthly bill pay. • Trust established in 2 business days guaranteed • Process of bill requests in 3 business days guaranteed (no more late bills) • Dedicated trust counselor	Yes (Trust I)

	assigned to each trust client • Fillable Joinder Agreement	
NYSARC, Inc. Trust Services 29 British American Blvd Latham, NY 12110 (Use this address for Fed Ex or UPS - otherwise use mailing address below) **Mailing address** NYSARC Inc. Trust Services POB 1531 Latham, NY 12110 (but use regular address for UPS or Fed Ex) Telephone: (518) 439-8323 Toll Free: (800) 735-8924 Facsimile: (518) 439-2670 E-mail: trustdept@nysarc.org http://nysarctrustservices.org	**Community Trust I - Self-Settled trust for asset protection** • Minimum deposit: $300, including $200 one-time enrollment fee - non-refundable • FEES: ◦ $25 annual accounting fee charged every July ◦ $1/month Allocation Fee ◦ Co-trustee fee of 0.75% annually charged at monthly rate of .0625% based upon balance at end of preceding month ◦ Plus, the greater of: ▪ 0.9% annual rate, charged monthly at .075% of average monthly assets OR ▪ Flat fee of $10/mo. • Intended for lump-sums, not monthly spend-down • Remainder at beneficiary's death is retained by trustee **Community Trust II – self-settled for Medicaid Spend Down (Surplus Income)** • Minimum initial deposit - $300, includes $200 one-time enrollment fee - non-refundable • Minimum balance equal to the	Yes (Community Trust II)

monthly spend-down is recommended for overdraft protection and emergency needs, but NYSARC will waive the minimum balance deposit for someone enrolled in their e-deposit program.

- E-deposit Program - electronic deposits of surplus income (at no additional cost)
- Automatic payments of rent and other regular bills
- FEES:
    - $50 annual accounting fee (July)
    - $1/month Allocation Fee
    - Pro rata share of annual audit, tax preparation costs for Trust
    - Co-trustee fee of 0.75% annually charged at monthly rate of .0625% based upon balance at end of preceding month
    - Plus, the greater of:
        - 0.9% annual rate, charged monthly at .075% of average monthly assets OR
        - Flat fee ranging from $30-$240 depending upon amount of monthly contribution (if over $4,000, contact NYSARC to determine fee) (Fee schedule

posted online)

Community Trust III -Self-settled for Assets of $250K+

- No enrollment fee
- Minimum deposit: $250,000
- Intended for lump-sums, not monthly spend-down
- Administration of Medicare Set-Aside accounts available
- Monthly fee of 0.06% or 0.075% depending upon balance, plus trustee bank fee not to exceed 0.0625% (0.75% annually)
- Potential for remainder Beneficiary if there are funds left after any possible state(s) Medicaid payback is fulfilled

GENERAL FEATURES OF NYSARC TRUSTS:

- NO ANNUAL RENEWAL FEE (some other trusts charge up to $200/year)
- Unlimited disbursement requests (some others charge up to $10 for each additional disbursement)
- 24/7 access to account information via automated phone system
- Fully-staffed beneficiary support team by phone
- Phone line exclusively for professionals to reach NYSARC management quickly
- 48-hour approval of new trusts (expedited approvals with prior notice)
- Prompt processing of

	disbursement requests **NYSARC Chart Comparing 3 Pooled Community Trusts** Links to Documents for all 3 Pooled Community Trusts	
Protect Your Family (PYF) 303 Merrick Road, Suite 505 Lynbrook, NY 11563 Tel: 516-837-3737 Fax: 516-837-9430 Email: info@pyftrust.org Website: pyftrust.org	Medicaid Pooled Income Trust • $300 application fee • $200 annual fee • Sliding scale monthly fee, based on surplus amount • Can pay the monthly fee on a monthly basis or pay for the full year in advance (10% off if paying for the year) Medicaid Asset Trust • $300 application fee • 2.0% annual administrative fee • $150 renewal fee	Yes
SCS Pooled Trust 1404 Coney Island Avenue Brooklyn, NY 11230 Telephone: 718-971-2509 Fax: 844-623-0481 Email: info@seniorcommservice.org www.seniorcommservice.org	• $250 Enrollment Fee • Monthly administrative fee of 10% of monthly required deposit (Min. $25/Max. $200) • Unlimited disbursements • No Minimum balance requirement • No Minimum funding requirement • $100 Renewal Fee • Monthly deposits can be made by ACH Direct Debit	Yes
The Rose and Maurice Halpern Lifetime Care	**The Lifetime Care Foundation**	Yes

Foundation at OHEL 156 Beach 9th Street Far Rockaway, NY 11691 718 686 3170 http://www.ohelfamily.org/?q=lifetime_care/pooled-trusts Email: lcftrusts@ohelfamily.org	**Community Pooled Trust I** • Third-party trust • A portion of the funds can be invested • An initial deposit minimum of $20,000 must be received in order for a client's funds to be invested. The first $10,000 is kept in a liquid account, and the next $10,000 is invested. At a point when the liquid $10,000 reaches a balance of $0, money will be divested from the investment account to the liquid account in increments of $10,000 **The Lifetime Care Foundation Community Pooled Trust II** • Self-settled trust • For those clients wishing to deposit liquid assets into a trust in order to preserve government entitlements, while having a portion of this money invested • An initial deposit minimum of $20,000 must be received in order for a client's funds to be invested. The first $10,000 is kept in a liquid account, and the next $10,000 is invested. At a point when the liquid $10,000 reaches a balance of $0, money will be divested from the investment account to the liquid account in increments of $10,000 **The Lifetime Care Foundation**

	Community Pooled Trust III
	
	• Self-settled trust
	• Can enable disabled individuals and seniors to use their excess income to pay for their own supplemental needs, such as rent, utilities, and medical services not covered by Medicaid and/or other entitlements programs
	
	Fees
	
	• $900 annual fee (first year's fee due at initiation)
	• $10 fee per check for any payments in excess of three per month
	• For Trusts I & II only:
	  ◦ Investment fees of approximately .75% from Bernstein Global Wealth Management
	  ◦ 1% investment fund management fee (if placed in investment account)
	  ◦ Annual investment fees:
	  ▪ 1.5% for $25,000-$250,000
	  ▪ 1% for the next $250,000-1 Million
	  ▪ 0.5% for additional amounts over 1 Million	

The Theresa Foundation Pooled Trust of New York 250 Lido Boulevard Lido Beach, NY 11561	**The Theresa Pooled Trust** • Self-settled trust	Yes

(516) 432-0449 http://www.theresafoundation.org Administered by **The Center for Special Needs Trust Administration, Inc.** 4912 Creekside Drive Clearwater, FL 33760 (877) 766-5331 http://www.centersweb.com http://centersweb.com/SNT/types_pooled_state.html	• Annual fee of 2% of trust assets • One-time administrative fee of $2,500 • Designed for sheltering lump-sums **The Theresa Pooled Income Trust** • Self-settled trust • One-time opening fee of $175 • Monthly service fee of $25 - $200, depending upon amount of monthly contribution • Monthly maintenance fee of 0.875% of account balance • Designed for sheltering excess income **The Theresa Foundation Community Trust** • Third-party trust	
UJA-Federation Community Trust Program Department of Planned Giving and Endowments 130 E. 59th street, 10th Floor New York, NY 10022 https://ujafedny.giftplans.org/index.php?cID=238&mID=12 Irina Tuchina (212) 836-1150 tuchinai@ujafedny.org Advocacy Service for trust beneficiaries: **The Jewish Board - SNT – Supplemental Needs Trust for Individuals with Disabilities** 1358 56th Street	**Community Trust for Disabled Adults** • Third-party trust • Minimum deposit: $100,000, with at least $20,000 invested initially with remainder to be deposited within 4 years • Beneficiary is assigned an advocate from a UJA agency • Annual fees: UJA-Federation administrative $1,500/yr. and advocacy $5,000/first yr. then $3,000/yr. • Upon the death of the beneficiary, 100% of the remainder is designated as per the Sponsor	No

Brooklyn, NY 11219 https://jewishboard.org/ Phone 718.851.7100 Fax 718.871.5811	**Community Trust II** • Self-settled trust • Minimum deposit: $50,000, payable over 5 years if necessary • Beneficiary is assigned an advocate from a UJA agency if full advocacy services are selected • Annual fees: UJA-Federation administrative $1,500/yr. and financial only advocacy $2,000/yr. or full advocacy $5,000/first yr. then $3,000/yr. • Upon the death of the beneficiary, 50% shall be maintained in the Trust and the other 50% is first subject to a Medicaid right of recovery. If Medicaid has no claim these funds can be designated by the Sponsor.	
UCS Disability Pooled Trust 1575 50th Street 3rd Fl Brooklyn, NY 11219 Ph: (718) 854-9300 Fax: (718) 506-9314 Email: trustdept@ucsbp.org http://www.ucstrustservices.org/index.html	**Trust A** • Self-settled trust • Enrollment fee: $250 • Minimum deposit: $1,000 • Annual fee of 2.5% of principal for deposits of $1,000 - $30,000; no additional fee for amounts in excess of $30,000 • Annual renewal fee: $200 **Trust B** • Self-settled trust • Enrollment fee: $250 • Minimum deposit: $100 • Monthly fee of 10% of required	Yes

	monthly deposit (minimum $30/mo., maximum of $200/mo.) • Annual renewal fee: $100 • Monthly contributions can be made by ACH direct debt from bank account	
Westchester ARC Foundation 121 Westmoreland Avenue White Plains, NY 10606 http://www.westchesterarc.org/ Anne Sweazey (914) 428-8330, ext. 3336 asweazey@westchesterarc.org	Community Trust I - third-party trust Community Trust II - self-settled trust	No
Western New York Coalition Pooled Trusts Go to www.wnypooledtrust.org for downloads, and more information Contact: Rachel Schepart (716) 853-3087 ext. 227 Trustees: **People Inc. & Legal Services for the Elderly, Disabled or Disadvantaged of WNY, Key Bank (fiscal trustee)** Only available to Erie, Niagara, Cattaraugus, Chautauqua and Allegany Counties	**WNY Coalition Pooled Medicaid Payback Trust (Trust #1)** • Self-settled trust • Accepts income deposits • No minimum deposit • Initiation fee: $100 • Monthly fee sliding scale based on amount deposited **WNY Coalition Over 65 Pooled Trust (Trust #2)** • Self-settled trust • Accepts income deposits • Only for individuals aged 65 or older • No minimum deposit • Initiation fee: $100 • Monthly fee sliding scale based on amount deposited **WNY Coalition Under 65 Pooled Trust (Trust #1) and Over 65 Pooled Trust**	Yes - but only for Erie, Niagara, Cattaraugus, Chautauqua and Allegany Counties Fee Schedule Income Only

(Trust #2)

- Self-settled trust
- Accepts lump sums without a minimum deposit
- Initiation fee: 10% of Deposit not to exceed $1,000
- Annual commission:
    - $10.50 per thousand on the first $400,000
    - $ 4.50 per thousand on the next $600,000
    - $ 3.50 on the balance in the pooled trust
    - Plus additional annual commission by bank trustee
- Semi-annual accounting fee: $6
- Termination fee: 1% of all amounts paid out

WNY Coalition Friends and Family Trust

- Third-party trust
- Only 25% of balance remainder at the death of the beneficiary is retained by trustees. Remaining 75% can be directed to others.
- Initiation fee: 10% of Deposit not to exceed $1,000
- Annual commission:
    - $10.50 per thousand on the first $400,000
    - $ 4.50 per thousand on the next $600,000
    - $ 3.50 on the balance in the pooled trust
    - Plus additional annual

	commission by bank trustee • Semi-annual accounting fee: $6 • Termination fee: 1% of all amounts paid out	
YAI / National Institute for People with Disabilities 460 West 34th Street New York, NY 10001-2382 http://www.yai.org/ (212) 563-7474	• Serves DD/MR/MI/ Phys Disabled, TBI. • Minimum deposit $25,000 with some flexibility.	No

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This article was authored by the Evelyn Frank Legal Resources Program of New York Legal Assistance Group.

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Revision: 61
Medicaid -> Supplemental Needs Trusts -> List of Pooled SNTs in New York State
http://www.wnylc.com/health/entry/4/

caringkind The Heart of Alzheimer's Caregiving

360 Lexington Avenue, 4th Fl.
New York, NY 10017
caringkindnyc.org
F: 212-697-6037

24-hour Helpline
P: 646-744-2900
helpline@caringkindnyc.org

Spousal Impoverishment Protections

On Sept. 24, 2013, New York State announces that spousal impoverishment protections are available to married participants in Managed Long Term Care (MLTC) plans. Prior to this, spousal impoverishment protections were only available to nursing home and Lombardi (long term home health care program) participants.

The Lombardi Program is being phased out so without these protections married Lombardi participants would have been at financial risk. Now that Lombardi participants will be moving into MLTC plans, they will maintain these spousal protections. The policy expands on GIS 12 MA/013, which relates to traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) waiver programs.

Spousal impoverishment protections were enacted by Congress in 1988 to protect spouses of nursing home residents. Under previous law, the spouse who remains at home was not given an allowance on which to survive. The law put into effect allowances for community spouses to live on.

New York State has always exercised the federal government's option of applying the spousal impoverishment protections to the Lombardi program (long term health care program) and other waivers. Although threatened at some points over the years by the federal government, participants in the Lombardi program who have a community spouse have had eligibility determines under spousal impoverishment budgeting if that worked better for the recipient.

The 2013 directive published this month refers to the 2012 directive that extended spousal budgeting to TBI or NHTD waiver programs and explained how spousal impoverishment protections were being implemented. It gives recipients a choice of using the move advantageous option of two budgeting methodologies for income:

The first option is spousal impoverishment budgeting, which includes deducting from the applicants income:

> An amount to bring his spouse's income up to the "Minimum Monthly Maintenance Needs Allowance" (MMMNA), which is $3,259.50 in 2021. The allowance provided to the non-applying spouse is called a "community spouse monthly income allowance" (CSMIA). The CSMIA is calculated by subtracting from the MMMNA ($2,898) the non-applying spouse's own income and the monthly cost of his/her health premiums (e.g. $2,898 MMMNA MINUS $200 medical insurance premiums = $498); a Family Member allowance (FMA), if applicable, is allowance of $647 per dependent family member up to a maximum of $1,939 (2013) and a Personal Needs Allowance (PNA) for the waiver participants, which is $375 in 2013 (the difference between the regular Medicaid level for ONE PERSON and TWO PERSON households).

Please Turn Over

The second option is community budgeting where an MLTC/Waiver participant's own income is budgeted, after deducting all income disregards (including the $20 monthly disregard) available in the community SSI related Medicaid recipients. The net income is compared to the regular Medicaid level of $800/month (2013). In some cases it may be favorable than the spousal impoverishment allowance.

In advising Agencies how to calculate, GIS 12 MA/013 indicated that it would only advantageous to the recipient to apply the post-eligibility rules if the CSMIA, plus FMA, is applicable, exceeds $445 ($453 in 2013). In other words, if the non-applying spouse's income, after deductions for health insurance premiums, is less than $2,453 per month, then the spousal impoverishment rule is more favorable.

Under both budgeting options, spousal impoverishment rules are to be applied to the couple's resources.

This budgeting will be new to many Medicaid workers so it is necessary to request spousal budgeting. Those who want budgeting before renewal will have to request it.

This article was taken from Elder Law Review, October, 2013

Medicaid Managed

Long Term Care

Your options for home care and other long term care services

Medicaid Managed Long Term Care

Managed Long Term Care Plans help provide services and support to people with a long-lasting health problem or disability. These Plans are approved by the New York State Department of Health to provide Medicaid managed long term care.

A Plan can provide your Medicaid home care and other long term care benefits. **To get these services, you may be required to join a Plan**.

This Guide tells you who must join a Plan, how the different Plans work, and other important things you should know. The Guide can also help you select a Plan.

New York Medicaid Choice – We can help

New York Medicaid Choice is a State program. Counselors will answer your questions and assist you over **the phone or TTY**. If you have trouble reading or understanding this Guide, we can help. We speak all languages.

New York Medicaid Choice
1-888-401-6582
or TTY: 1-888-329-1541

Monday to Friday, 8:30 am – 8:00 pm
Saturday, 10:00 am – 6:00 pm

This Guide is available on CD and in Braille

Table of Contents

What is a Managed Long Term Care Plan?

What is a Plan?

Each Plan has its own group of home care agencies, professionals and other providers. This group is the Plan's **network of providers.** After you join a Plan, you must get your services from the Plan's providers.

You will have a person-centered Plan of Care, which means that you will have an active role in planning your services. You will have a **Care Manager** who will get to know you and talk with you about your service needs. Your Care Manager will assist you and anyone else you want to involve, in developing a **Plan of Care** that meets your specific needs.

There are three different types of Plans. You will learn about these Plans and how they work in the next section of this Guide.

- **MLTC Medicaid Plan**
- **Medicaid Advantage Plus**
- **Program of All-Inclusive Care for the Elderly (PACE)**

Who Must Join a Plan?

You must join a Plan if:

- You have both Medicaid and Medicare
- You need home care, adult day health care, or other long term care for more than 120 days (four months)
- You are age 21 or older.

I Get Home Care Now. Do I Have to Join a Plan?

Yes – you must join a Plan if you received a letter from **New York Medicaid Choice** telling you to join a Plan by a certain date. The Plan you select will take over your care and approve your services. If you do not select a Plan, the Medicaid Program will assign you to one of the **MLTC Medicaid Plans** in your borough or county.

How Long Do I Stay with a Plan?

A Plan must approve your services for as long as you qualify for home care and other long term care services. You decide what Plan you want. To change Plans, call **New York Medicaid Choice**.

What Services Will I Get From a Plan?

All Plans provide Medicaid home care and other community long term care services.

Some Plans also provide Medicare and Medicaid services, including doctor office visits, hospital care, pharmacy and other health-related services. If you join a Plan that covers these health services, you must get your care from the Plan's doctors and other providers.

MLTC Medicaid Plan	**Medicaid Advantage Plus**	**PACE**
Medicaid long-term care	Medicaid long-term care **and** Medicare health services	Medicaid long-term care **and** Medicare/ Medicaid health services

In the next section, you will learn more about the three types of Plans and the services they provide.

Step 1 Pick the type of Plan you want

How to Choose a Plan

Selecting a Managed Long Term Care Plan is important. Discuss your Plan options with your family, doctor, or the person who helps you make your health care decisions.

You can also take the three steps in this Guide to help you select a Managed Long Term Care Plan.

Your first step is to pick the type of Plan you want. In the next few pages, three Plan Members describe their type of Plan and they also tell you why they chose it. You can then decide which Plan you prefer.

MLTC Medicaid Plan

"I didn't want to change doctors or anything with my Medicare services. That's why I chose a MLTC Medicaid Plan. My Plan focuses solely on home care and my other long term care services. It's separate from Medicare. So when I see my primary care doctor or need any Medicare services, I still use my Medicare card."

Plan Services

Here are some of the services provided by a MLTC Medicaid Plan

As a Plan member, you are free to keep seeing your Medicare or Medicare Advantage doctor or other provider of services not covered by the Plan.

Medicaid long term care services

- **Health Services at your home**
  - Nurses
  - Home Health Aides
  - Physical Therapists
- **Personal Care**
  - Help with bathing, dressing, and grocery shopping
- **Adult Day Health Care**
- **Social Day Care**
- **Nursing Home Care**
- **Specialty Health**
  - Audiology
  - Dental
  - Optometry
  - Podiatry
  - Physical Therapy
- **Other Services**
  - Home-delivered meals
  - Personal emergency response
  - Transportation to medical appointments
  - Consumer Directed Personal Assistance Services

Medicaid Advantage Plus Plan

"I like getting all my care from one Plan. It's why I chose Medicaid Advantage Plus. My Plan manages both my Medicaid and Medicare services. Now my doctors, hospital, and home care agency are all in the same Plan."

You must also join the Plan's Medicare Product. You choose a Primary Care Physician (PCP) from the Plan to be your regular doctor.

Plan Services

Here are some of the services provided by a Medicaid Advantage Plus Plan

Medicaid long term care services

- **Health Services at your home**
  - Nurses
  - Home Health Aides
  - Physical Therapists
- **Personal Care**
  - Help with bathing, dressing, and grocery shopping
- **Adult Day Health Care**
- **Social Day Care**
- **Nursing Home Care**

Specialty Health

- Audiology
- Dental
- Optometry
- Podiatry
- Physical Therapy

Other Services

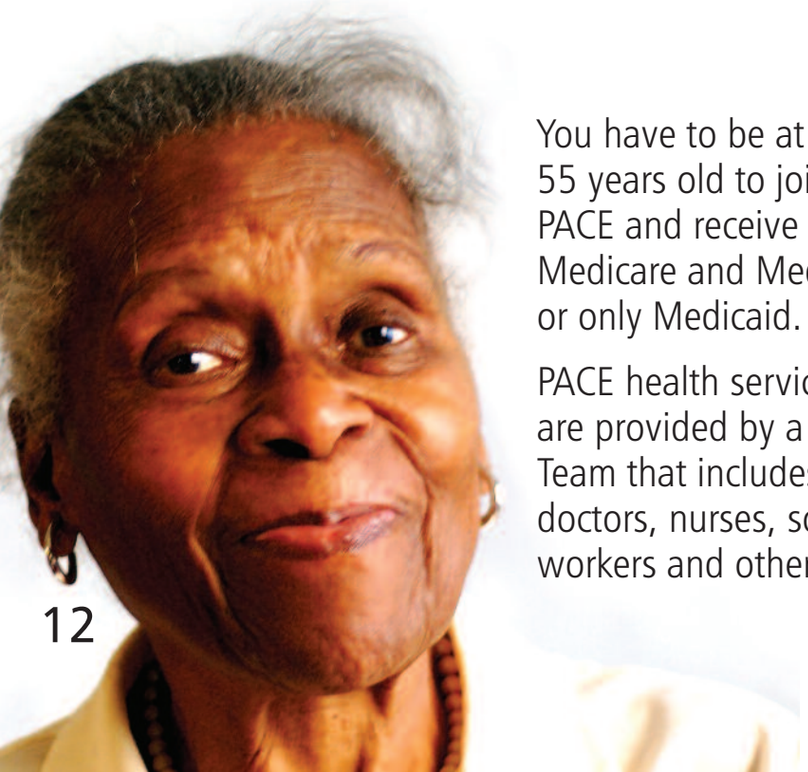
- Home-delivered meals
- Personal emergency response
- Transportation to medical appointments
- Consumer Directed Personal Assistance Services

Medicare Services

- Doctor office visits
- Specialty care
- Clinic visits, hospital stays
- Mental health services
- X-ray and other Radiology services
- Chiropractic care
- Medicare Part D drug benefits
- Ambulance services

Program of All-Inclusive Care for the Elderly PACE

"I don't like to be alone at home so I chose PACE because of the Plan's adult day center. I can spend the day there with other Plan members. My doctor and Care Team are also at the day center so I get my health services there as well. "



You have to be at least 55 years old to join PACE and receive Medicare and Medicaid or only Medicaid.

PACE health services are provided by a Team that includes doctors, nurses, social workers and others.

Plan Services

Here are some of the services you get from PACE

Medicaid long term care services

- **Health Services at your home**
  Nurses
  Home Health Aides
  Physical Therapists
- **Personal Care**
  Help with bathing, dressing, and grocery shopping
- **Adult Day Health Care**
- **Social Day Care**
- **Nursing Home Care**
- **Specialty Health**
  Audiology
  Dental
  Optometry
  Podiatry
  Physical Therapy
- **Other Services**
- Home-delivered meals
- Personal emergency response
- Transportation to medical appointments

Medicare and Medicaid Services

- Doctor office visits
- Specialty care
- Clinic visits, hospital stays
- Mental health services
- X-ray and other Radiology services
- Chiropractic care
- Medicare Part D drug benefits
- Ambulance services

Step 2 Fill out the Provider Worksheet

Provider Worksheet

Make a list of the agencies and other providers you want to see after you join a Plan. You can keep or change the providers you have now. It's your choice.

Write their names here.

Personal Care or Home Attendant Agency

Certified Home Health Agency

Consumer Directed Personal Assistance Program Fiscal Intermediaries

Other Agency or Professional who visits you at home

Adult Day Health Care Program

Dentist

Optometrist (eye doctor)

Podiatrist (foot doctor)

If you are interested in Medicaid Advantage Plus or PACE:

Your PCP (Primary Care Physician)

Your Specialty Physician

Step 3 Enroll in Your Plan

Call New York Medicaid Choice

1-888-401-6582
TTY: 1-888-329-1541

You have the right to choose the Plan that best meets your needs. To assist you, our counselors will answer your questions and also:

- **Look up** which Plans work with the home care agency and other providers you want
- **Enroll** you in a MLTC Medicaid Plan over the phone or TTY
- **Explain** how to join Medicaid Advantage Plus or PACE. Our counselors can then connect you by phone to the Plan you want to join.

After You Join a Plan

After you enroll in a Plan, you will get a confirmation letter from **New York Medicaid Choice** that tells you the date when you start with your new Plan.

You will also get a Member Handbook and a Plan Identification Card from your new Plan. Your Member Handbook includes the services your Plan provides and other important information.

Your Care Manager will also work with you and anyone else you want to involve, to assess your service needs and develop a Plan of Care. Your Plan of Care will describe the services you will get from your Plan.

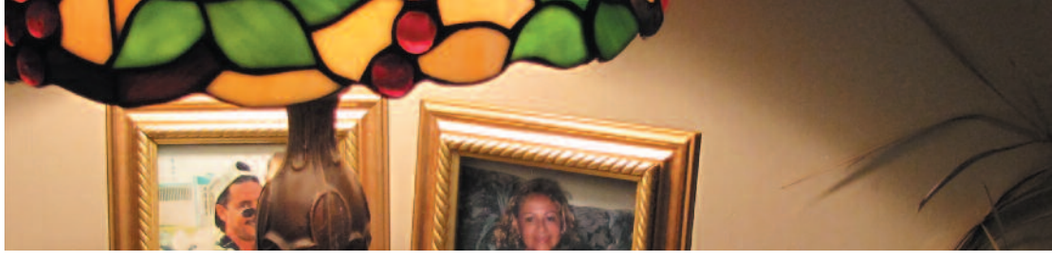
Transitional care

You can keep the home care and other long term care services you have now for the first 90 days in your new Plan.

If you have needs related to a disability

Your Plan will provide the support you need, such as:

- Information in large print or other formats
- TTY services for people who have trouble hearing or speaking



- Staff who can help you fill out forms and explain any information
- Plan providers with wheelchair access or other accommodations
- Help with any issues accessing care from providers.

Your Rights as a Plan Member

As a Plan member, you have certain rights, such as the right to:

- Get timely access to services that help with or prevent a health problem or disability
- Be told where, when and how to get needed services from your Plan or outside the Plan
- Be told what you need to know to give informed consent about your care
- Take part in decisions about your health care including the right to refuse treatment
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status, or religion
- Privacy about your medical record and when you get treatment
- Get a copy of your medical records and to ask that the records be amended or corrected

- Be treated with respect and dignity
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience or retaliation.

Your Responsibilities as a Plan Member

As a Plan member, you also have responsibilities.

You should always:

- Use providers who work with the Plan for covered services
- Get approval from your Care Manager or care team before receiving a covered service
- Tell the Plan about your care needs and concerns
- Tell the Plan when you go away or out of town
- Some people with a certain income must pay a surplus amount (also called spend down) to get Medicaid benefits. As a Plan member, you are responsible for paying this amount to the Plan.

Changing Plans

If you want to change Plans, contact the Plan you want to join. If you are not sure which Plan you want to select – call **New York Medicaid Choice**. Our counselors will be glad to assist you.

Your Plan must continue to arrange and pay for your services until your new Plan takes over. Disenrollment takes place at the end of the month.

Unless you are not required to join a Plan, you must remain in a Plan to receive long term care services in your community. You can not receive these services outside a Plan.

Problem Solving

Feel free to speak to your Care Manager about any concerns you may have with your Plan of Care or services. If you are still not satisfied with the results of your complaint, you may also call:

- **New York Medicaid Choice** at 1-888-401-6582. Our counselors will contact the Plan and try to help you resolve the problem.
- **State Department of Health** at 1-866-712-7197.

What is a Grievance?

A grievance is a way of making a complaint. If you are not happy with something about your services or with someone from the Plan, you can complain. You or someone on your behalf can file a grievance in writing, over the phone or in person. Your Plan will work with you to resolve the problem.

What is an Appeal?

If your Plan denies, reduces, or ends services that you think you should have – you can appeal. The Plan will take another look at your service needs and will send you a letter with their decision. If you still are not satisfied, you can ask for a **Fair Hearing**.

When you ask for a Fair Hearing – the Medicaid Program will listen to your case and make a decision.

Who Does Not Have to Join a Plan

The following people are not required to join a Managed Long Term Care Plan. They may join a Plan if they want:

- Native Americans
- Adults age 18–20 who need more than 120 days of community-based long term care
- Adults who are nursing home eligible and enrolled in the Medicaid Program for the working disabled

People receiving the following services cannot join a Managed Long Term Care Plan. In some cases, you may leave your program to join a Plan.

- People enrolled in an Assisted Living Program
- People enrolled in the Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion
- People receiving hospice services or who are residents of a psychiatric or residential care facility or nursing home

- People who have a developmental disability and receiving care in a facility, in the community or through a waiver program
- People who live in Family Care Homes licensed by the Office of Mental Health
- Residents of alcohol and drug abuse residential treatment programs
- People who have Medicaid eligibility only for tuberculosis-related services
- People who are uninsured and receiving breast and cervical cancer services and those who are under age 65 and eligible for the early detection program
- People who have Medicaid eligibility only for breast and cervical cancer services
- People who are eligible for family planning expansion program
- People with less than 6 months of Medicaid eligibility or eligible for emergency Medicaid only.

Contact New York Medicaid Choice if you are receiving any of the above services and you have questions. Counselors will be glad to assist you.

Call: 1-888-401-6582
TTY: 1-888-329-1541

New York Medicaid Choice

1-888-401-6582

TTY: 1-888-329-1541

nymedicaidchoice.com

caringkind

The Heart of Alzheimer's Caregiving

Medicaid Levels for 2024

Medicaid Figures	2024
Income level for one person	$1,732*
Income level for two people	$2,351
Resource level for one person household	$31,175
Resource level for two person household	$42,1312
Minimum Monthly Maintenance Needs (Income) Allowance	$3,853.50
Maximum Community Spouse Resource Allowance	$154,140**

In addition, $543 is the Personal Needs Allowance for certain waiver participants subject to spousal impoverishment budgeting. The home equity limit for Medicaid coverage of long-term care increased to $1,071,000(subject to certain exceptions).

*plus an additional $20 monthly per household for aged, blind, or disabled applicants

**minimum of $74,820 or one-half of the married couple's resources, up to a maximum of $154,140.

New York City Plan List

New York City
MLTC Medicaid Plans

What services will these Plans provide?

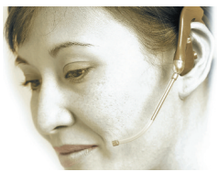
- **Medicaid home care and other long term care services, including:** personal care (home attendants), home health aides, adult day health care, consumer directed personal assistance services, dental care, transportation, and other services.
- **No Medicare services.**
- **What else should I know?**
  You can keep seeing your Medicare or Medicare Advantage doctor and other providers of services not covered by the Plan.

MLTC Medicaid Plans

	Contact	Service Area
Aetna Better Health	1-855-456-9126 TTY: 711 www.aetnabetterhealth.com	Brooklyn, Queens, Manhattan
AgeWell New York	1-866-586-8044 TTY: 1-800-662-1220 www.agewellnewyork.com	Bronx, Brooklyn, Queens, Manhattan
AlphaCare of New York, Inc.	1-888-770-7815 TTY: 711 www.alphacare.com	Bronx, Brooklyn, Queens, Manhattan
ArchCare Community Life	1-855-467-9351 TTY: 711 www.archcare.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
Centerlight Healthcare Select MLTC	1-877-226-8500 TTY: 1-800-650-2774 www.centerlight.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
Centers Plan for Healthy Living	1-855-270-1600 TTY: 1-800-421-1220 www.centersplan.com	Bronx, Brooklyn, Queens, Manhattan, Staten Island
ElderServe Health, Inc.	1-800-370-3600 TTY: 1-866-236-5800 www.elderservehealth.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island

MLTC Medicaid Plans

	Contact	Service Area
Extended MLTC	1-855-299-6492 TTY: 711 www.extendedmltc.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
Fidelis Care at Home	1-800-688-7422 TTY: 1-800-695-8544 www.fideliscare.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
GuildNet	1-800-932-4703 TTY: 1-800-662-1220 www.guildnetny.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
HealthPlus, an Amerigroup Company MLTC	1-800-950-7679 TTY: 1-800-855-2880 www.myamerigroup.com	Bronx, Brooklyn, Queens, Manhattan, Staten Island
HHH Choices Health Plan, LLC	1-866-663-6877 TTY: 1-718-678-1537 www.hhhchoices.org	Bronx, Brooklyn, Queens, Manhattan
HIP MLTC, an EmblemHealth Company	1-888-447-9161 TTY: 1-888-447-4833 www.emblemhealth.com	Bronx, Brooklyn, Queens, Manhattan, Staten Island
HomeFirst, a product of Elderplan	1-866-389-2656 TTY: 1-800-662-1220 www.homefirst.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
Independence Care System	1-877-427-2525 TTY: 711 www.icsny.org	Bronx, Brooklyn, Queens, Manhattan
Integra MLTC, Inc.	1-855-661-0002 TTY: 711 www.integraplan.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
MetroPlus Managed Long Term Care	1-855-355-6582 TTY: 1-800-881-2812 www.metroplus.org	Bronx, Brooklyn, Queens, Manhattan
Montefiore HMO Managed Long Term Care	1-855-556-6683 TTY: 711 www.montefiore.org/healthplans-medicaid	Bronx
North Shore-LIJ Health Plan, Inc.	1-855-421-3066 TTY: 855-871-1665 www.nslijhealthplans.com	Brooklyn, Queens, Manhattan, Staten Island



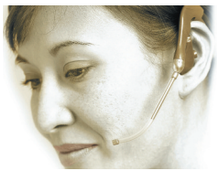
Questions?

1-888-401-MLTC or 1-888-401-6582
(TTY: 1-888-329-1541)
New York Medicaid Choice

MLTC-MED-PL-E-0114

MLTC Medicaid Plans

	Contact	Service Area
Senior Health Partners A Healthfirst Company	1-866-585-9280 TTY: 1-800-662-1220 www.shpny.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
Senior Whole Health of New York MLTC	1-877-353-0185 TTY: 711 www.seniorwholehealth.com	Bronx, Brooklyn, Queens, Manhattan
UnitedHealthcare Personal Assist	1-877-512-9354 TTY: 711 www.uhccommunityplan.com	Bronx, Brooklyn, Queens, Manhattan, Staten Island
VillageCareMAX	1-800-469-6292 TTY: 1-800-662-1220 www.villagecaremax.org	Bronx, Brooklyn, Queens, Manhattan
VNSNY CHOICE Managed Long Term Care	1-888-867-6555 TTY: 711 www.vnsnychoice.org	Bronx, Brooklyn, Queens, Manhattan, Staten Island
WellCare Advocate MLTC	1-866-661-1232 TTY: 1-877-247-6272 www.newyork.wellcare.com	Bronx, Brooklyn, Queens, Manhattan, Staten Island



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About health plans: learn the basics, get your questions answered.

Ask

Do I qualify for managed long term care?

About Health Plans

About Long Term Care Plans

Getting Care

Making Changes

What Are My Rights?

What is the FIDA-IDD Program?

Quick Links

- Learn about your choices
- Choose your health plan
- Enroll by phone
- Brochures & lists

Do I qualify for managed long term care?

If you need home care or adult day health care - this is a good place to start. The CFEEC, a New York State Medicaid program, may be able to help.

What is the Conflict-Free Evaluation and Enrollment Center (CFEEC)?

The CFEEC is a program that determines if you need Medicaid community-based long term care for at least 120 days. If you do, you may qualify for managed long term care and get home care and other long term care services. You can get these services from a Medicaid-approved managed care plan.

To schedule an evaluation, call 855-222-8350. TTY: 888-329-1541.

How is the CFEEC free of any conflict of interest?

The organization that conducts the evaluations for New York State is not affiliated with any managed care plan, or with any provider of health care or long term care services.

Who needs an evaluation?

A person who wants to join a Medicaid-approved long term care plan for the first time. You also need an evaluation if you have not been in a plan for 45 days or longer. Learn about these long term care plans.

Who can ask for an evaluation?

Reach Us

1-800-505-5678

1-888-401-6582
(Long term care customer services)

TTY 1-888-329-1541

Monday - Friday
8:30 a.m. - 8:00 p.m.

Saturday
10:00 a.m. - 6:00 p.m.

Quick Assist

Have questions? We're here to help. Our counselors will be glad to answer your questions. We can also help you choose a plan over the phone. All languages are spoken.

Everyone is welcomed to schedule an evaluation and you don't need a referral from your doctor. However, you must be eligible for Medicaid to receive any services through the Medicaid program.

What is an evaluation?

A registered nurse from the Evaluation Center will visit you to learn about your care needs. The nurse will ask you questions developed by the Department of Health to determine if you qualify for services. The evaluation does not include a medical exam.

How do I schedule an evaluation?

Call the Evaluation and Enrollment Center at 1-855-222-8350. TTY: 1-888-329-1541. Counselors speak all languages.

I have more questions

Counselors will be glad to answer your questions over the phone. You may call anytime from Monday - Friday, from 8:30 am to 8:00 pm and Saturday, from 10:00 am to 6:00 pm. The phone call and help are free.

About health plans: learn the basics, get your questions answered.

Ask

Do I qualify for managed long term care?

About Health Plans

» Health Plan Services

» Who Does Not Have to Join a Health Plan

About Long Term Care Plans

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About Health Plans

Your health plan will make sure you see the right doctor when you need to. A health plan has its own group of doctors, hospitals and other providers. You choose one of the doctors from your plan to be your Primary Care Provider (PCP). NYC Medicaid members living with HIV or who are transgender or qualify as homeless can join an HIV Special Needs Plan. Dependent children can also join an HIV Special Needs Plan with their parents.

Your Primary Care Provider (PCP)

Your PCP will get to know you and will keep track of your medical history. Your PCP will also refer you to specialists and to services, such as laboratory tests. If you see a specialist often, your specialist can be your PCP.

Joining a Medicaid health plan

Most New Yorkers with Medicaid must join a health plan to get their care. If you do not choose a plan, the Medicaid Program will choose one for you. If you want help in choosing a plan, call New York Medicaid Choice.

Some people do not have to join a plan

Some people with Medicaid do not have to or cannot join a Plan because of a medical condition or other reason. You can find a complete list of who does not have to join a health plan on the left hand side of this page. Call New York Medicaid Choice to learn more.

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New York Medicaid Choice is the managed care enrollment program of the New York State Department of Health.