



# FAMILY INDEPENDENCE ADMINISTRATION


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## POLICY BULLETIN #14-04-ELI

### OBSOLETE PD #01-69-ELI (MEDICAL ASSISTANCE PROGRAM OUTREACH)

<b>Date:</b> January 21, 2014	<b>Subtopic(s):</b> Supplemental Nutrition Assistance Program (SNAP)
<p> This procedure can now be accessed on the FIAweb.</p>	<p>The purpose of this policy bulletin is to inform Non Cash Assistance (NCA) Supplemental Nutrition Assistance Program (SNAP) Center staff that PD #01-69-ELI (Medical Assistance Program Outreach) is now obsolete. This PB is informational for all other staff.</p> <p>NCA SNAP Centers no longer handle applications for Medical Assistance. The following forms are obsolete:</p> <ul style="list-style-type: none"> <li>• Referral for a Medicaid Eligibility Determination (<b>M-42g</b>);</li> <li>• Transmittal to Medical Assistance Programs (<b>M-42j</b>); and</li> <li>• Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Centers and Associated Medicaid Offices (<b>M-42u</b>).</li> </ul> <p>NCA SNAP Center Directors must ensure that all forms and their multilingual equivalents are removed from circulation and recycled.</p> <p>Samples of the obsolete forms are attached.</p> <p>NCA SNAP Center staff should inform individuals who want to apply for Medical Assistance to call 311 or the HRA InfoLine at (718) 557-1399, or write to the address below to obtain more information:</p> <p style="text-align: center;">Medical Assistance Program Correspondence Unit 785 Atlantic Avenue, 1st Floor Brooklyn, NY 11238.</p> <p><i>Effective Immediately</i></p>

HAVE QUESTIONS ABOUT THIS PROCEDURE?  
Call 718-557-1313 then press 3 at the prompt followed by 1 or  
send an e-mail to *FIA Call Center Fax* or fax to: (917) 639-0298

**Attachments:**

🖨 Please use Print on Demand to obtain copies of forms.

- M-42g** Referral for a Medicaid Eligibility Determination (Obsolete)
- M-42g (S)** Referral for a Medicaid Eligibility Determination (Spanish) (Obsolete)
- M-42j** Transmittal to Medical Assistance Programs (Obsolete)
- M-42u** Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Centers and Associated Medicaid Offices (Obsolete)
- M-42u (S)** Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Centers and Associated Medicaid Offices (Spanish) (Obsolete)



To: Medical Assistance Program

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

NPA FS Office: \_\_\_\_\_

NPA FS  
Case Number: \_\_\_\_\_

NPA FS  
Case Name: \_\_\_\_\_

CIN: \_\_\_\_\_

### Referral for a Medicaid Eligibility Determination

The above-named case applied for food stamps on \_\_\_\_\_  
Application Filing Date

**Applying for Medicaid:** \_\_\_\_\_  
Date of Interview

#### HOUSEHOLD COMPOSITION

Name	Relationship to Head of Household	Date of Birth	Social Security Number (not needed for pregnant women)	Sex (M/F)
	Self			

Include **all** adults with a legal relationship to applying children; do not include adults without a legal relationship.

#### SHELTER

Home Address: \_\_\_\_\_

Shelter Type (select one)	Monthly Expense	Name(s) of Individual(s) Paying Shelter Expense
Own Home	\$	
Private Apartment	\$	
Single Room Occupancy (SRO)	\$	
Other ( <i>specify</i> )	\$	

**INCOME**

**RESOURCES**

Income Source	Household Member	Gross Monthly Amount	Resources	Household Member	Value/ Amount
Employment		\$	Stocks, Bonds, CDs		\$
Retirement/Pension		\$	Checking Account		\$
Worker's Comp.		\$	Savings Account		\$
UIB		\$	Life Insurance Policy (face and cash value)		\$
NYS Disability		\$	Automobile		\$
Other		\$	Other		\$

**CURRENT CHILD/DEPENDENT CARE EXPENSES**

Child/Dependent Care Type	Household Member	Monthly Amount
		\$
		\$
		\$

**ILLNESS/INJURY**

Is anyone who is applying blind, disabled, handicapped or have a chronic illness or special health care need?

No  Yes If yes, list name and details: \_\_\_\_\_

Does anyone applying have an injury, illness or disability that was caused by someone else or that could be covered by insurance other than health insurance (such as homeowner's or auto insurance)?

No  Yes If yes, list name and details: \_\_\_\_\_

Does anyone applying have unpaid or recently paid medical bills from the past three (3) months? (Medicaid or Child Health Plus A may be able to pay these bills.)

No  Yes If yes, list name and details: \_\_\_\_\_

**INSURANCE**

Name of Insurance Company: \_\_\_\_\_

Monthly Premium	Policy Number	Group Number	Insurance Code	HMO Indicator	Effective Date
\$					
Names of Persons Covered					
(1)			(3)		
(2)			(4)		

**CITIZENSHIP**

**Pregnant women do not have to complete this section. Almost all children are eligible for health insurance, regardless of immigration status listed below.**

Is everyone who is applying a U.S. citizen?  No  Yes (If yes, do not complete the section below.)

If NO, please enter the following information for anyone applying for health insurance who is not a U.S. citizen (*answers to these questions will be kept confidential*). For each person check the appropriate status box. If the person belongs to category A or B (see category descriptions below), remember to enter the requested date in the last column.

Name	Status	(Earliest) Arrival Date in U.S.
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> None	
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> None	
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> None	

**Category A:** Legal Permanent Resident (green card holder), Asylee, Cuban/Haitian Entrant, Parolee for at least one year, Native American born in Canada who is at least 50 percent Native American, some battered immigrants and/or children, Refugee, Withholding of Deportation, Conditional Entrant, Amerasian.

**Category B:** Order of Supervision, Deferred Action status, Parolee for less than one year, covered by an approved immediate relative petition, properly filed or granted application for adjustment of status, has continuously lived in the United States since before January 1, 1972, living in the United States with the knowledge and permission or acquiescence of the United States Citizenship and Immigration Services (USCIS) and whose departure USCIS does not contemplate enforcing.

OBSOLETE

\_\_\_\_\_

Casehead's Signature

Date

\_\_\_\_\_

Name of Worker

Date



To: Medical Assistance Program

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fecha: \_\_\_\_\_  
Número de Caso \_\_\_\_\_  
NPA FS: \_\_\_\_\_  
Nombre del Caso \_\_\_\_\_  
NPA FS: \_\_\_\_\_  
CIN: \_\_\_\_\_

### Envío para Determinar Elegibilidad de Medicaid

El caso mencionado más arriba ha solicitado cupones para alimentos el: \_\_\_\_\_  
Fecha en que se Presentó la Solicitud

En trámite de solicitud para Medicaid: \_\_\_\_\_

Fecha de la Entrevista

#### COMPOSICIÓN DEL HOGAR

Nombre	Relación al Jefe de Familia Si mismo	Fecha de Nacimiento	Número de Seguro Social (no es requerido a las mujeres embarazadas)	Sexo (M/F)

Incluya a **todos** los adultos que estén relacionados legalmente a los niños que solicitan; de otra manera no los incluya.

#### VIVIENDA

Dirección del Hogar: \_\_\_\_\_

Tipo de Vivienda (indique una)	Gastos Mensuales	Nombre(s) de Persona(s) que Paga(n) Gastos de Vivienda
Hogar Propio	\$	
Apartamento Privado	\$	
Vivienda de una sola habitación (SRO)	\$	
Otro (especifique):	\$	

**INGRESOS**

**RECURSOS**

Fuente de Ingreso	Miembro del Hogar	Cantidad Mensual Bruta	Recursos	Miembro del Hogar	Valor/Cantidad
Empleo		\$	Acciones, Bonos, CDs		\$
Retiro/Pensión		\$	Cuenta Corriente		\$
Compensacion de Empleo para el Trabajador		\$	Cuenta de Ahorros		\$
Beneficios de Desempleo		\$	Póliza de Seguro de Vida (valor nominal y en efectivo)		\$
NYS Incapacidad		\$	Automóvil		\$
Otras Fuentes		\$	Otros Recursos		\$

**GASTOS ACTUALES DE CUIDADO DE DEPENDIENTES/NIÑOS**

Tipo de Cuidado de Dependiente/Niños	Miembro del Hogar	Cantidad Mensual
		\$
		\$
		\$

**ENFERMEDAD/LESIONES**

¿Es uno de los solicitantes una persona ciega, incapacitada, inválida, o padece de una enfermedad crónica o de algún malestar que requiera cuidado médico especial?

No  Sí De ser así, escriba el nombre y detalle: \_\_\_\_\_

¿Padece uno de los solicitantes de una lesión, enfermedad o incapacidad que haya sido causada por otra persona o que la pueda cubrir otro seguro que no sea de salud (tal como el seguro de propietario de vivienda o seguro de vehículo)?

No  Sí De ser así, escriba el nombre y detalle: \_\_\_\_\_

¿Tiene uno de los solicitantes facturas sin pagar o recientemente pagadas de los últimos tres meses (Medicaid o Child Health Plus A puede saldarle esas cuentas)?

No  Sí De ser así, escriba el nombre y detalle: \_\_\_\_\_

**SEGURO**

Nombre de la Compañía de Seguros: \_\_\_\_\_

Prima Mensual	Número de Póliza	Número de Grupo	Código de Seguro	Índice de HMO	Fecha en Vigor
\$					
Nombres de las Personas en la Cobertura					
(1)			(3)		
(2)			(4)		

**CIUDADANÍA**

**Las mujeres embarazadas no tienen que llenar esta sección. Casi todos los niños son elegibles para seguro de salud, sin importar su estado de inmigración listado más abajo.**

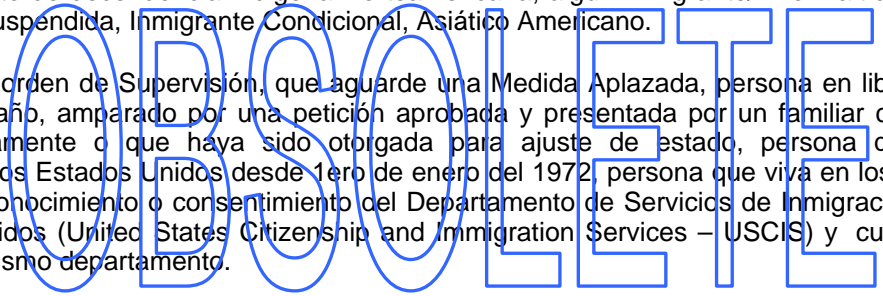
¿Son todos los solicitantes ciudadanos estadounidenses?  No  Sí  
(De ser así, no llene la sección de abajo.)

De NO ser ciudadano, favor de proporcionar la siguiente información de todas las personas que solicitan seguro de salud y que no sean ciudadanos estadounidenses (*las respuestas a estas preguntas serán confidenciales*). Para cada persona marque la casilla de estado migratorio correspondiente. Si la persona pertenece a la categoría A o B (vea las descripciones de cada categoría más abajo), asegúrese de anotar la fecha requerida en la última columna.

Nombre	Estado Migratorio	(Más Temprana) Fecha de Entrada a los EE.UU.
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Ninguno	
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Ninguno	
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> Ninguno	

**Categoría A:** Residente Legal Permanente (usuario de tarjeta verde), Asilado, Inmigrante Cubano/Haitiano, Persona convicta en libertad provisional por menos de un año, Persona Indígena Americana nacida en Canada con un 50 por ciento de descendencia Indígena Norteamericana, algún inmigrante/niño maltratado, Refugiado, con Deportación Suspendida, Inmigrante Condicional, Asiático Americano.

**Categoría B:** Con orden de Supervisión, que aguarde una Medida Aplazada, persona en libertad provisional por menos de un año, amparado por una petición aprobada y presentada por un familiar cercano, solicitud presentada debidamente o que haya sido otorgada para ajuste de estado, persona que haya vivido continuamente en los Estados Unidos desde 1ero de enero del 1972, persona que viva en los Estados Unidos con el permiso y conocimiento o consentimiento del Departamento de Servicios de Inmigración y Ciudadanía de los Estados Unidos (United States Citizenship and Immigration Services – USCIS) y cuya salida no sea procurada por el mismo departamento.



\_\_\_\_\_  
Firma del Jefe de Familia

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Nombre del Trabajador

\_\_\_\_\_  
Fecha





**Transmittal to Medical Assistance Programs**

From: NPA/FS Center \_\_\_\_\_

Date: \_\_\_\_\_

To: Medical Assistance Programs  
\_\_\_\_\_  
\_\_\_\_\_

Total Number of Application Interviews: \_\_\_\_\_

Total Number of Recertification Interviews: \_\_\_\_\_

Total Number of M-42g forms Received: \_\_\_\_\_

Subject: Referral packages for cases/individuals for Separate Determination of Medicaid eligibility.

**Please check the applicable box: APP-Application, RECERT-Recertification, NONAPP-Not Applying for MA**

NO	APP	RECERT	NON-APP	CASE HEAD		CIN
				Last Name	First Name	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

OBSOLETE

Total number of M-42g forms: \_\_\_\_\_

Prepared by: \_\_\_\_\_

FS Center Designee  
(print)

\_\_\_\_\_  
FS Center Director  
(print)

Telephone Number: \_\_\_\_\_

## Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP) Centers and Associated Medicaid Offices

To file a Supplemental Nutrition Assistance Program (SNAP) application, you may appear in person at any of the SNAP Centers listed below between the hours of 8:30 AM and 5:00 PM, Monday through Friday. In Extended Hours Centers you may appear in person between the hours of 8:30 AM and 6:00 PM, Monday through Friday and between 9:00 AM and 5:00 PM on Saturday. You may also mail your application to the **Division of SNAP Services, Mail Application & Referral Unit (MARU), P.O. Box 24510, Brooklyn, NY 11201**, or fax your application to (917) 639-1111, or apply on line at [www.nyc.gov/accessnyc](http://www.nyc.gov/accessnyc) or [www.mybenefits.ny.gov](http://www.mybenefits.ny.gov). To request an application and instructions on the documentation requirements, call Infoline at (718) 557-1399.

SNAP Center	Associated Medicaid Office
<b>SNAP Center 02 East End</b> 2322 Third Avenue, Third Floor New York, NY 10035	<b>Harlem Hospital</b> (Ron Brown Building) 530 Lenox Avenue, First Floor, Room 1061 (137th Street entrance) New York, NY 10037
<b>SNAP Center 13 Washington Heights</b> 4055 Tenth Avenue, Lower Level New York, NY 10034	<b>Columbia-Presbyterian Hospital</b> 622 West 168th Street, First Floor, Room PH040 New York, NY 10032
<b>SNAP Center 14 St. Nicholas</b> 132 West 125th Street, Third Floor New York, NY 10027	<b>Harlem Hospital</b> (Ron Brown Building) 530 Lenox Avenue, First Floor, Room 1061 (137th Street entrance) New York, NY 10037
<b>SNAP Center 19 Waverly*</b> 12 West 14th Street, Fourth Floor New York, NY 10011	<b>Bellevue Hospital</b> 462 First Avenue "G" Link, Ground Floor New York, NY 10016
<b>SNAP Center 20 Fort Greene*</b> 275 Bergen Street, First Floor Brooklyn, NY 11217	<b>Boerum Hill</b> 35 4th Avenue Brooklyn, NY 11217
<b>SNAP Center 21 Williamsburg</b> 30 Thornton Street, Fourth Floor Brooklyn, NY 11206	<b>Woodhull Hospital</b> 760 Broadway, Ground Floor Brooklyn, NY 11206
<b>SNAP Center 22 Coney Island</b> 10 Bouck Court, First Floor Brooklyn, NY 11224	<b>Coney Island</b> 3050 West 21st Street, First Floor Brooklyn, NY 11224
<b>SNAP Center 26 North Brooklyn</b> 500 DeKalb Avenue, Fourth Floor Brooklyn, NY 11205	<b>Woodhull Hospital</b> 760 Broadway, Ground Floor Brooklyn, NY 11206
<b>SNAP Center 28 East New York</b> 404 Pine Street, First Floor Brooklyn, NY 11208	<b>East NY Medicaid Office</b> 2094 Pitkin Avenue Brooklyn, NY 11208

\*Extended Hours Centers – 8:30 AM to 6:00 PM, Monday through Friday and between 9:00 AM and 5:00 PM on Saturday.

**Non Cash Assistance Supplemental Nutrition Assistance Program (NCA SNAP)  
Centers and Associated Medicaid Offices**

<b>SNAP Center</b>	<b>Associated Medicaid Office</b>
<b>SNAP Center 40 Melrose</b> 260 East 161st Street, Third Floor Bronx, NY 10451	<b>Lincoln Hospital</b> 234 East 149th Street, Basement, Room B-75 Bronx, NY 10451
<b>SNAP Center 45 Concourse*</b> 1375 Jerome Avenue, Second Floor Bronx, NY 10452	
<b>SNAP Center 46 Crotona</b> 1910 Monterey Avenue, Fifth Floor Bronx, NY 10457	<b>Bronx Lebanon Hospital</b> 1316 Fulton Avenue, First Floor Bronx, NY 10456
<b>SNAP Center 53 Queens</b> 32-20 Northern Boulevard, Second Floor Long Island City, NY 11101	<b>Elmhurst Hospital</b> 79-01 Broadway, Room D4-17 Elmhurst, NY 11373
<b>SNAP Center 54 Jamaica*</b> 165-08 88th Avenue, Third Floor Jamaica, NY 11432	<b>Jamaica</b> 165-08 88th Avenue, Sixth Floor Jamaica, NY 11432
<b>SNAP Center 79 Rockaway</b> 219 Beach 59th Street, First Floor Rockaway, NY 11692	<b>Rockaway</b> 219 Beach 59th Street, Second Floor Rockaway, NY 11692
<b>SNAP Center 99 Richmond*</b> 201 Bay Street, Second Floor Staten Island, NY 10301	<b>Staten Island</b> 215 Bay Street Staten Island, NY 10301

\*Extended Hours Centers – 8:30 AM to 6:00 PM, Monday through Friday and between 9:00 AM and 5:00 PM on Saturday.

## Centros de Programa de Asistencia de Nutrición Suplementaria de No Asistencia en Efectivo (NCA SNAP) y Oficinas de Medicaid Correspondientes

Para presentar una solicitud del Programa SNAP puede presentarse a cualquiera de los Centros de Programa SNAP indicados abajo entre las horas de 8:30 AM a 5:00 PM de lunes a viernes. En Centros con Horario Suplementario, usted puede presentarse entre las horas de 8:30 AM y 6:00 PM, de lunes a viernes y entre 9:00 AM a 5:00 PM el sábado. También puede enviar por correo su solicitud a los Servicios de la **División del Programa de SNAP, Unidad de Referencia y Solicitud por Correo (MARU)** al **P. O. Box 24510, Brooklyn, NY 11201** o enviar por fax su solicitud al (917) 639-1111, o presente solicitud en por Internet en [www.nyc.gov/accessnyc](http://www.nyc.gov/accessnyc) o en [www.mybenefits.ny.gov](http://www.mybenefits.ny.gov). Para pedir una solicitud e instrucciones para los requisitos documentales llame al la Línea Informativa (Infoline) al (718) 557-1399.

Centro de SNAP	Oficina de Medicaid Correspondiente
<b>Centro de SNAP 02 East End</b> 2322 Third Avenue, 3er piso New York, NY 10035	<b>Harlem Hospital</b> (Edificio Ron Brown) 530 Lenox Avenue, 1er piso, sala 1061 (entrada en la 137th Street) New York, NY 10037
<b>Centro de SNAP 13 Washington Heights</b> 4055 Tenth Avenue, planta baja New York, NY 10034	<b>Columbia-Presbyterian Hospital</b> 622 West 168th Street, 1er piso, sala PH040 New York, NY 10032
<b>Centro de SNAP 14 St. Nicholas</b> 132 West 125th Street, 3er piso New York, NY 10027	<b>Harlem Hospital</b> (Edificio Ron Brown) 530 Lenox Avenue, 1er piso, sala 1061 (entrada en la 137th Street) New York, NY 10037
<b>Centro de SNAP 19 Waverly*</b> 12 West 14th Street, 4to piso New York, NY 10011	<b>Bellevue Hospital</b> 462 First Avenue "G" Link planta baja New York, NY 10016
<b>Centro de SNAP 20 Fort Greene*</b> 275 Bergen Street, 1er piso Brooklyn, NY 11217	<b>Boerum Hill</b> 35 4th Avenue Brooklyn, NY 11217
<b>Centro de SNAP 21 Williamsburg</b> 30 Thornton Street, 4to piso Brooklyn, NY 11206	<b>Woodhull Hospital</b> 760 Broadway, planta baja Brooklyn, NY 11206
<b>Centro de SNAP 22 Coney Island</b> 10 Bouck Court, 1er piso Brooklyn, NY 11224	<b>Coney Island</b> 3050 West 21st Street, 1er piso Brooklyn, NY 11224
<b>Centro de SNAP 26 North Brooklyn</b> 500 Dekalb Avenue, 4to piso Brooklyn, NY 11205	<b>Woodhull Hospital</b> 760 Broadway, planta baja Brooklyn, NY 11206
<b>Centro de SNAP 28 East New York</b> 404 Pine Street, 1er piso Brooklyn, NY 11208	<b>East NY Medicaid Office</b> 2094 Pitkin Avenue Brooklyn, NY 11208

\*Centros con Horario Suplementario – 8:30 AM a 6:00 PM, lunes a viernes y entre 9:00 AM y 5:00 PM el sábado.

**Centros de Programa de Asistencia de Nutrición Suplementaria de No Asistencia en Efectivo (NCA SNAP) y Oficinas de Medicaid Correspondientes**

Centro de SNAP	Oficina de Medicaid Correspondiente
<b>Centro de SNAP 40 Melrose</b> 260 East 161st Street, 3er piso Bronx, NY 10451	<b>Lincoln Hospital</b> 234 East 149th Street, sótano, sala B-75 Bronx, NY 10451
<b>Centro de SNAP 45 Concourse*</b> 1375 Jerome Avenue, 2do piso Bronx, NY 10452	
<b>Centro de SNAP 46 Crotona</b> 1910 Monterey Avenue, 5to piso Bronx, NY 10457	<b>Bronx Lebanon Hospital</b> 1316 Fulton Avenue, 1er piso Bronx, NY 10456
<b>Centro de SNAP 53 Queens</b> 32-20 Northern Boulevard, 2do piso Long Island City, NY 11101	<b>Elmhurst Hospital</b> 79-01 Broadway, sala D4-17 Elmhurst, NY 11373
<b>Centro de SNAP 54 Jamaica*</b> 165-08 88th Avenue, 3er piso Jamaica, NY 11432	<b>Jamaica</b> 165-08 88th Avenue, 6to piso Jamaica, NY 11432
<b>Centro de SNAP 79 Rockaway</b> 219 Beach 59th Street, 1er piso Rockaway, NY 11692	<b>Rockaway</b> 219 Beach 59th Street, 2do piso Rockaway, NY 11692
<b>Centro de SNAP 99 Richmond*</b> 201 Bay Street, 2do piso Staten Island, NY 10301	<b>Staten Island</b> 215 Bay Street Staten Island, NY 10301

\*Centros con Horario Suplementario – 8:30 AM a 6:00 PM, lunes a viernes y entre 9:00 AM y 5:00 PM el sábado.