Supplement 8-1C

FAMILY INDEPENDENCE ADMINISTRATION

Seth W. Diamond, Executive Deputy Commissioner

James K. Whelan, Deputy Commissioner
Policy, Procedures and Training

Lisa C. Fitzpatrick, Assistant Deputy Commissioner
Office of Procedures

POLICY BULLETIN #05-27-OPE

REVISION TO THE REFERRAL TO HSS MEDICAL EXAMINATION FORM

Date: February 16, 2005	**Subtopic(s):** Forms
This procedure can now be accessed on the FIAweb.	The purpose of this policy bulletin is to inform staff that form **W-538C** has been renamed "Medical Provider Appointment" to accommodate future changes in medical provider vendors, and has been revised to consolidate a variety of medical appointment notices. The new **W-538C** will be generated in NYCWAY with the use of the following action codes:

920S	Agency Sanction Referral to HSS
938H	Applicant HSS Appointment Scheduled
938K	CSM Referral to HSS
938N	HSS Appointment Scheduled – SN Compliance
938W	Brad H. Applicant Referral to HSS
938Z	Brad H. Applicant Reschedule to HSS
968A	Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Referral for Mandatory Specialty Medical Assessment
968W	Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Referral for Mandatory Assessment
103H	Time Limit Call In SNA Applicant: HSS Referral
103N	TANF Time Appointment: Online Sanction Referral to HSS
138J	Undercare Referral to HSS
138K	CSM Referral to HSS
138M	HSS Appointment Scheduled
138R	Referred to HSS for Completion of Functional Assessment
138T	Tempu Return for Functional Assessment
138V	HSS Appointment Scheduled – Out of County Client
138W	Brad H. Undercare Referral to HSS
138Z	Brad H. Undercare Reschedule to HSS

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call (718) 557-1313 then press 2 at the prompt followed by 765 or
send an e-mail to *FIA Call Center*

Distribution: X

168A	Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Referral for Mandatory Specialty Medical Assessment
168C	Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Referral for a New and Acute Medical Condition
168W	Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Referral for Mandatory Assessment
169A	Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Referral for Mandatory Specialty Medical Assessment
210Q	HSS Referral – Long Term SA Program Participant
240H	SA Clinical Assessment Outcome HSS Scheduled
13HA	Fair Hearing Reevaluation Required Refer to HSS
13HB	Refer to HSS – New/Current Condition Changed
13HR	Rescheduled HSS Appointment
13HW	Appointment to HSS to Initiate Wellness/Rehab Plan
93HR	Rescheduled HSS Appointment

These forms are now obsolete.

As a result of the new **W-538C** template, the following referral notices and their multilingual equivalents are now obsolete:

W-533	Mandatory Appointment at HS Systems
W-533C	13HA - Medical Reassessment as Advanced by Fair Hearing Decision
W-533D	13HB - New Medical Claim or Condition Worsened
W-533E	138R - Completion of Medical Evaluation
W-533F	138T - Temporary Medical Deferral Expiration
W-538G	Initial Referral to HSS Medical Examination

Center Directors must ensure that all previous versions of form **W-538C**, and the obsolete forms referenced above, are recycled.

Effective Immediately

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

Attachments:

W-538C	Medical Provider Appointment (Rev. 2/16/05)
W-538C(S)	Medical Provider Appointment (2/16/05)

Obsolete Forms:

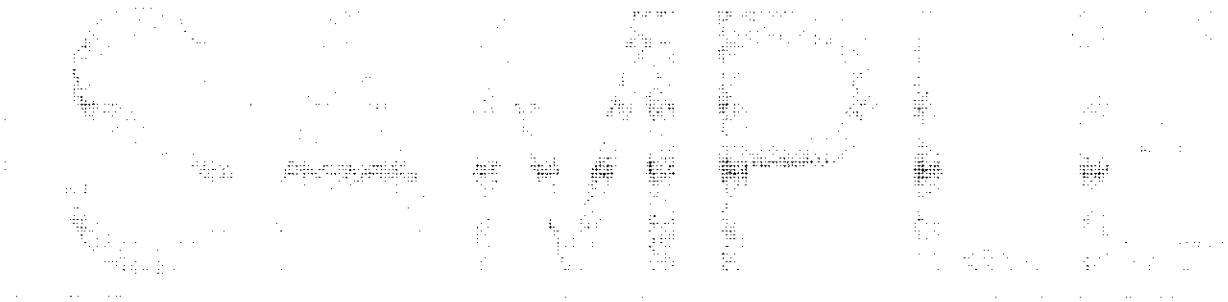
W-533	Mandatory Appointment at HS Systems (Obsolete)
W-533C	13HA - Medical Reassessment as Advanced by Fair Hearing Decision (Obsolete)
W-533D	13HB - New Medical Claim or Condition Worsened (Obsolete)
W-533E	138R - Completion of Medical Evaluation (Obsolete)
W-533F	138T - Temporary Medical Deferral Expiration (Obsolete)
W-538G	Initial Referral to HSS Medical Examination (Obsolete)

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date:
Case Number: _____
Case Name: _____
Case Type: _____
Center:
Action Code:

Medical Provider Appointment

You must report to HRA's medical provider for the reason listed below.



Appointment Date: _____ Time: _____ Telephone: _____

Location: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Travel Directions: _____

The goal of a medical assessment is to identify medical problems. Based on the outcome of your assessment, if it is determined that you have medical/mental health problems, the medical provider will work with you to develop a plan that will restore you to the best possible level of health and self-sufficiency.

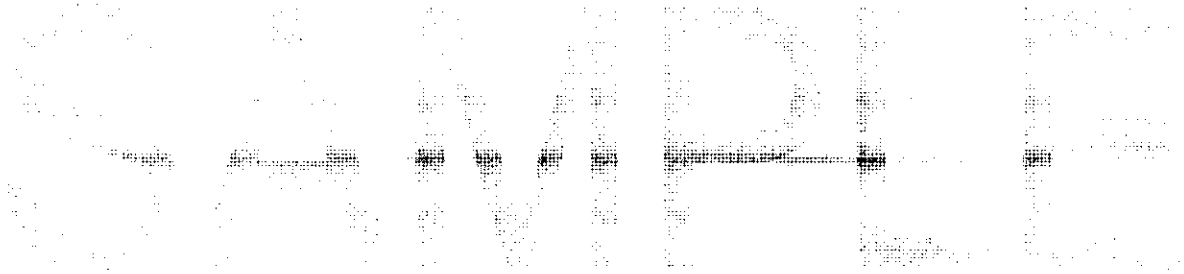
This is a mandatory public assistance eligibility appointment. Failure to report and comply with this appointment may result in the denial/closing of your public assistance case. If you are receiving non-public assistance food stamps and fail to keep this appointment, you may be considered work rules required.

If you cannot keep the medical provider appointment, or need special accommodations, please call the phone number listed above for assistance before your scheduled appointment time.

Please bring this letter, your Social Security card and your photo ID/Medicaid card, if available. You should also bring any recent doctor's letter, prescriptions or other forms that may provide information on your condition.

You may have someone accompany you to this appointment if you require assistance. All HRA medical provider facilities are handicapped accessible.

If you do not report to HRA's medical provider within one (1) hour of your appointment, you may not be seen.

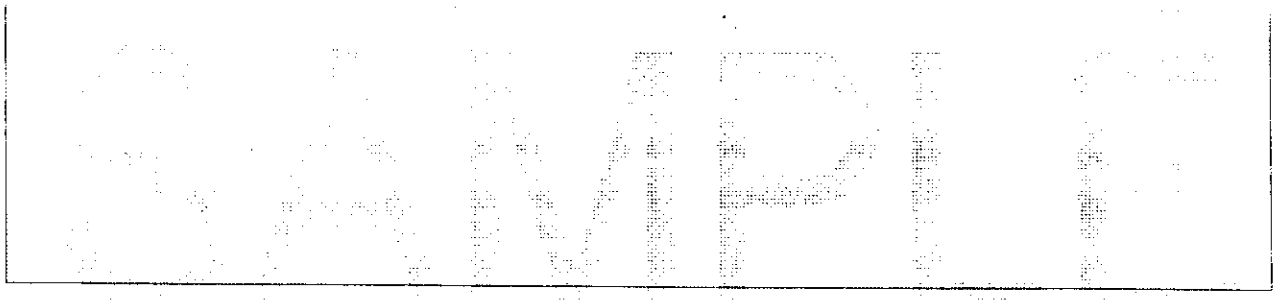


The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Fecha: _____
Nombre de Caso: _____
Número del Caso: _____
Tipo de Caso:
Centro: _____
Código de Acción: _____

Cita con el Proveedor Médico

Se le esta enviando a un proveedor médico de la HRA por el siguiente motivo:



Fecha de la Cita: _____ Hora: _____ Teléfono: _____

Local: _____

Dirección: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Indicaciones de Viaje: _____

El objetivo de la evaluación médica es el detectar problemas de salud que le afecten. Conforme a los resultados de su evaluación, si se determina que usted padece de problemas de salud físicos/mentales, el proveedor médico elaborará un plan junto a usted que le ayudará a restaurar su mejor nivel de salud y autosuficiencia posible.

Esta es una cita obligatoria de elegibilidad de asistencia pública. El no presentarse y no cumplir esta cita como debido puede resultar en la denegación o el cierre de su caso de asistencia pública. Si usted recibe cupones para alimentos fuera de asistencia pública, y no cumple la cita, puede ser considerado como persona obligado(a) a cumplir las reglas de trabajo.

Si usted no puede acudir a la cita con el proveedor médico, o si necesita que se hagan adaptaciones especiales, por favor comuníquese al número anotado más arriba antes de su cita programada.

Favor de traer esta carta, su tarjeta de Seguro Social y de identificación/Medicaid, si están disponibles. Usted debe además traer cualquier carta del médico, receta u otros formularios que puedan proveer información sobre su estado.

Usted puede venir acompañado(a) de alguien a esta cita si necesita ayuda. Todos los locales de proveedores médicos de la HRA **están dotados de acceso para incapacitados.**

Si no se presenta al local del proveedor médico de la HRA dentro de (1) hora de su cita, puede que no se le atienda.

SAMPLE

Form W-533 MLF
Rev. 3/18/04

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date:
Case Number:
Case Name:
Case Type:
CIN:
Center:
Caseload:
Action Code:

Mandatory Appointment at HS Systems

Dear Applicant/Participant:

You must report to HS Systems:

OBSOLETE

The goal of the medical examination is to determine your employability so that we can find an HRA-approved work activity that prepares you for employment.

Appointment Information

Appointment Date: _____ Day: _____ Time: _____ Phone: _____

Location:
Location Name
Address Line 1
City State Zip Code

Travel Directions:

You must attend this appointment at the address indicated above. If you do not report to HSS within one hour of your appointment, you may not be seen. If, for any reason, you cannot keep this appointment, please call _____ prior to your scheduled appointment time.

Before Exam: Do not eat or drink anything except water for three hours before your medical appointment. If a doctor has prescribed medicine, you should continue to take it.

Bring to the Exam: Bring this letter, your Social Security card and photo ID/Medicaid card with you to the examination. You should also bring any recent doctors' letters, test results, prescriptions and/or forms such as the Physician's Employability Report (Form **W-538**) that may provide information on your medical condition. If you need someone to accompany you, we request that they wait outside of the HS Systems office since there is limited seating in the reception area.

This is a mandatory eligibility appointment public assistance and/or Food Stamps.

Failure to report and comply with this appointment may result in the denial or closing of your public assistance case. If you are receiving non-public assistance food stamps, and fail to keep this appointment, you may be considered work rules required.

Sincerely,
Catherine McAlevey
Deputy Commissioner

Form W-533C (face)
10/17/02
Return Address (write or stamp in box below)

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____

Case Name: _____

Case Number:

Case Category: _____

SSN: _____

Action Code: 13HA _____

Fold Here

Fold Here

13HA- Medical Reassessment as Advanced by Fair Hearing Decision

OBSOLETE

Dear Participant:

In order to reassess your ability to comply with the work requirements, you are required to report to HS Systems for a medical reevaluation. This new medical assessment is being requested as part of a Fair Hearing determination.

You must report to HSS on:

Day/Date: _____ Time: _____ am/pm

Location: _____

Travel Directions: _____

Verified: _____

Please bring this letter, your Social Security card and your Medicaid photo ID card with you to this examination. You should also bring any recent doctors' letters, prescriptions and forms that may provide information on the progress of your condition.

If you do not report to HSS within one hour of your appointment you will not be seen. If, for any reason, you cannot keep this appointment, please call (___ ___) _____ prior to your scheduled appointment time.

Failure to report and comply with this appointment may result in the closing of your public assistance case.

Participant's Signature: _____ Date: _____

FIA Worker's Signature: _____ Date: _____

(vea al dorso)

Form W-533C (reverse)
10/17/02

Return Address (write or stamp in box below)

Human Resources Administration
Family Independence Administration

Fecha: _____

Nombre Del Caso: _____

Número del Caso:

Categoría de Caso: _____

NSS:

Código de Acción: 13HA

Fold Here

Fold Here

13HA- Revaluación Médica tal como Planteada por la Decisión de la Audiencia Imparcial

OBSOLETE

Estimado(a) Participante:

A fin de determinar de nuevo su aptitud para cumplir los requisitos de trabajo, se le requiere presentarse a los Sistemas de HS para un revaluación médica, tal como ha sido planteada por la decisión de la Audiencia Imparcial.

Usted tiene que presentarse a HSS el:

Dia/Fecha: _____ Hora: _____ am/pm

Local: _____

Indicaciones de Viaje: _____

Confirmado por: _____

Favor de traer con usted a este examen esta carta y sus tarjetas de Seguro Social y de identificación de Medicaid con foto. Además, usted debiera traer cualquier carta médica reciente, recetas y formularios que puedan proveer información acerca del progreso de su condición médica.

Si usted no se presenta a HSS dentro de una hora de la hora de su cita, no se le atenderá. Si por alguna razón, usted no puede cumplir con esta cita, favor de llamar al ( ) antes de su cita programada.

El no presentarse y no cumplir con esta cita como debido puede resultar en el cierre de su caso de asistencia pública.

Firma del Participante: Fecha:

Firma del Trabajador de FIA: _____ Fecha: _____

(See Other Side)

Form W-533D (face)
10/17/02
Return Address (write or stamp in box below)

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date:

Case Name:

Case Number:

Case Category:

SSN:

Action Code: 13HB

Fold Here

Fold Here

13HB- New Medical Claim or Condition Worsened

OBSOLETE

Dear Participant:

You claimed that you have either a new medical condition, or a condition that has worsened, preventing you from participating in work activities. In order to verify your medical claim, you are required to report to HS Systems for a medical reassessment.

You must report to HSS on:

Day/Date: Time: am/pm

Location:

Travel Directions:

Verified by:

Please bring this letter, your Social Security card and your Medicaid photo ID card with you to this examination. You should also bring any recent doctors' letters, prescriptions and forms that may provide information on the progress of your condition.

If you do not report to HSS within one hour of your appointment you will not be seen. If, for any reason, you cannot keep this appointment, please call (___) _____ prior to your scheduled appointment time.

Failure to report and comply with this appointment may result in the closing of your public assistance case.

Participant's Signature: _____ Date: _____

FIA Worker's Signature: _____ Date: _____

(vea al dorso)

Form W-533D (reverse)
10/17/02
Return Address (write or stamp in box below)

Human Resources Administration
Family Independence Administration

Fecha: _____

Nombre Del Caso: _____

Número del Caso:

Categoría de Caso: _____

NSS:

Código de Acción: 13HB

Fold Here

Fold Here

13HB- Nueva Reclamación Médica o Afección Agravada

OBSOLETE

Estimado(a):

Usted ha reclamado que padece de una nueva o agravada afección médica, lo cual le impide participar en las actividades de trabajo. A fin de comprobar dicha reclamación, se le requiere que se presente a los Sistemas de HS para una re-evaluación médica.

Usted tiene que presentarse a HSS el:

Día/Fecha: _____ Hora: _____ am/pm

Local: _____

Indicaciones de Viaje: _____

_____

Confirmado por: _____

Favor de traer con usted a este examen esta carta y sus tarjetas de Seguro Social y de identificación de Medicaid con foto. Además, usted debiera traer cualquier carta médica reciente, recetas y formularios que puedan proveer información acerca del progreso de su condición médica.

Si usted no se presenta a HSS dentro de una hora de la hora de su cita, no se le atenderá. Si por alguna razón, usted no puede cumplir con esta cita, favor de llamar al (___) _____ antes de su cita programada.

El no presentarse y no cumplir con esta cita como debido puede resultar en el cierre de su caso de asistencia pública.

Firma del Participante: Fecha:

Firma del Trabajador de FIA: _____ Fecha: _____

(See Other Side)

Form W-533E (face)
10/17/02
Return Address (write or stamp in box below)

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date:

Case Name:

Case Number:

Case Category:

SSN:

Action Code: 138R

Fold Here

Fold Here

138R- Completion of Medical Evaluation

OBSOLETE

Dear Participant:

In order to reassess your ability to comply with the work requirements, you are required to report to HS Systems for a medical reevaluation. This new medical assessment is being requested as part of a Fair Hearing determination.

You must report to HSS on:

Day/Date: _____ Time: _____ am/pm

Location: _____

Travel Directions: _____

_____

Verified: _____

Please bring this letter, your Social Security card and your Medicaid photo ID card with you to this examination. You should also bring any recent doctors' letters, prescriptions and forms that may provide information on the progress of your condition.

If you do not report to HSS within one hour of your appointment you will not be seen. If, for any reason, you cannot keep this appointment, please call ( ) prior to your scheduled appointment time.

Failure to report and comply with this appointment may result in the closing of your public assistance case.

Participant's Signature: _____ Date: _____

FIA Worker's Signature: _____ Date: _____

(vea al dorso)

Form W-533E (reverse)
10/17/02
Return Address (write or stamp in box below)

Human Resources Administration
Family Independence Administration

Fecha: _____

Nombre Del Caso: _____

Número del Caso: _____

Categoría de Caso: _____

NSS:

Código de Acción: 138R

Fold Here

Fold Here

138R- Finalización de la Evaluación Médica

Estimado(a):

A fin de determinar de nuevo su aptitud para cumplir los requisitos de trabajo se le requiere presentarse a los Sistemas de HS para un reevaluación médica, tal como ha sido planteado por la decisión de Audiencia Imparcial.

OBSOLETE

Usted tiene que presentarse a HSS el:

Dia/Fecha: _____ Hora: _____ am/pm

Local: _____

Indicaciones de Viaje: _____

_____

Confirmado por: _____

Favor de traer con usted a este examen esta carta y sus tarjetas de Seguro Social y de identificación de Medicaid con foto. Además, usted debiera traer cualquier carta médica reciente, recetas y formularios que puedan proveer información acerca del progreso de su condición médica.

Si usted no se presenta a HSS dentro de una hora de la hora de su cita, no se le atenderá. Si por alguna razón, usted no puede cumplir con esta cita, favor de llamar al (___) _____ antes de su cita programada.

El no presentarse y no cumplir con esta cita como debido puede resultar en el cierre de su caso de asistencia pública.

Firma del Participante: Fecha:

Firma del Trabajador de FIA: _____ Fecha: _____

(See Other Side)

Form W-533F (face)
10/23/02
Return Address (write or stamp in box below)

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date:

Case Name:

Case Number:

Case Category:

SSN:

Action Code: 138T_____

Fold Here

Fold Here

138T- Temporary Medical Deferral Expiration

OBSOLETE

Dear Participant:

Our records show that the last time your were contacted by our agency, you were temporarily medically deferred from participation in work activities.

We have scheduled a medical examination for you at HSS. Based on the doctor's findings we will work with you to find work activity in which you can participate.

You must report to HSS on:

Day/Date: Time: _____ am/pm

Location:

Travel Directions: _____

_____

Verified by: _____

Please bring this letter, your Social Security card and your Medicaid photo ID card with you to this examination. You should also bring any recent doctors' letters, prescriptions and forms that may provide information on the progress of your condition.

If you do not report to HSS within one hour of your appointment you will not be seen. If, for any reason, you cannot keep this appointment, please call ( ) _____ prior to your scheduled appointment time.

Failure to report and comply with this appointment may result in the closing of your public assistance case.

Participant's Signature: _____ Date: _____

FIA Worker's Signature: _____ Date: _____

(vea al dorso)

Form W-533F (reverse)
10/23/02
Return Address (write or stamp in box below)

Human Resources Administration
Family Independence Administration

Fecha: _____

Nombre Del Caso: _____

Número del Caso:

Categoría de Caso: _____

NSS:

Código de Acción: 138T

Fold Here

Fold Here

138T- Vencimiento de Aplazamiento Médico Temporario

Estimado(a):

Según nuestros archivos, la última vez que nuestra agencia se comunicó con usted, sus actividades de trabajo fueron aplazadas temporariamente por razones médicas.

Hemos programado un examen médico para usted con HSS. Basado en su último informe médico, nosotros le ayudaremos a encontrar una actividad de trabajo en la cual usted pueda participar.

Usted tiene que presentarse a HSS el:

OBSOLETE

Dia/Fecha: _____ Hora: _____ am/pm

Local: _____

Indicaciones de Viaje: _____

_____

Confirmado por: _____

Favor de traer con usted a este examen esta carta y sus tarjetas de Seguro Social y de identificación de Medicaid con foto. Además, usted debiera traer cualquier carta médica reciente, recetas y formularios que puedan proveer información acerca del progreso de su condición médica.

Si usted no se presenta a HSS dentro de una hora de la hora de su cita, no se le atenderá. Si por alguna razón, usted no puede cumplir con esta cita, favor de llamar al ( ) _____ antes de su cita programada.

El no presentarse y no cumplir con esta cita como debido puede resultar en el cierre de su caso de asistencia pública.

Firma del Participante: Fecha:

Firma del Trabajador de FIA: _____ Fecha: _____

(See Other Side)

Form W-538G (face)
10/29/02
Return Address (write or stamp in box below)

The CITY of NEW YORK
Human Resources Administration
Family Independence Administration

Date: _____

Case Name: _____

Case Number:

Responsibility Center: _____

Referring Center:

Action Code: _____

Fold Here

Fold Here

Initial Referral to HSS Medical Examination

Dear Applicant/Participant:

In order to evaluate your disability/employability you are required to have a medical/functional assessment evaluation. Special arrangements have been made to provide this examination to you free of charge.

OBSOLETE

You must report to HSS on:

Date: _____ Time: _____ ☐ A.M. ☐ P.M.

Location:

Travel Directions: _____

Verified by: _____

Fold Here

Fold Here

Please bring this letter, your Social Security card and your Medicaid photo identification card. You should also bring any recent doctors' letters, prescriptions and forms that may provide information on the progress of your condition.

If you do not report to HSS within one (1) hour of your appointment you will not be seen. If, for any reason, you cannot keep this appointment, please call _____, prior to your scheduled appointment time.

Failure to report and comply with this appointment may result in the closing of your public assistance case.

Sincerely,

Family Independence Administration

(see other side)

Form W-538G (reverse)
10/29/02
Return Address (write or stamp in box below)

Human Resources Administration
Family Independence Administration

Fecha: _____

Nombre del Caso: _____

Número del Caso:

Centro de Responabilidad: _____

Centro de Referencia:

Código de Acción: _____

Fold Here

Fold Here

Referencia Inicial al HSS para Examen Médico

Estimado(a) Solicitante/Participante:

Para poder estimar su incapacidad y/o empleabilidad se requiere que usted se haga una evaluación de funciones. Se han hecho arreglos especificos para proveerle este examen gratuitamente.

Usted tiene que presentarse a HSS el:

Fecha: _____ Hora: _____ ☐ A.M. ☐ P.M.

Lugar:

Indicacciones de Viaje: _____

_____

OBSOLETE

Confirmado por: _____

Fold Here

Fold Here

Favor de traer con usted a este examen esta carta y sus trajetas de Seguro Social y de identificación de Medicaid con foto. Además, usted debiera traer cualquier carta médica reciente, recetas y formularios

If you do not report to<u>HSS within one (1) hour of your appointment</u> you will not be seen. If, for any reason, you cannot keep this appointment, please call _____, prior to your scheduled appointment time.

Failure to report and comply with this appointment may result in the closing of your public assistance case.

Sincerely,

Family Independence Administration

(vea al dorso)