TO: Local District Commissioners, Medicaid Directors, Third Party Supervisors

FROM: Betty Rice, Director
Office of Medicaid Management

SUBJECT: QI-1 Re-enrollment Process Upstate NY

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit:
Upstate - 518-474-8887 NYC - 212-417-4500

As a result of recent legislation, the Qualified Individual 1 Program (QI-1) has been extended through September 30, 2007. This is to inform local departments of social services that the re-enrollment of the QI-1 Program for Upstate districts will now be initiated through the Client Notice System (CNS). Information for New York City cases will be forthcoming at a later date.

In the past when an individual was determined eligible for the QI-1 program, the case was recorded as denied on WMS. However, with the implementation of eMedNY and to facilitate the re-enrollment process, these cases are now entered on WMS as open cases.

On the weekend of 12/10/05, CNS will produce a Renewal Cover Letter and Renewal Re-enrollment Form which will be sent to active QI-1 enrollees who had cases systemically created in March 2005 and have a From Date of 3/1/05. They will then be required to complete, sign and return the renewal form to their local district office within 30 days from the date of the notice. At the same time a "QI-1 Renewal Report" listing the Case Numbers, Names and Return Dates of the individuals who will be receiving the letter and form will be produced and sent through the BICS queue to the local district offices. The list will be sorted by Fiscal District, Local Office Number, Unit Identifier, Client Identification Number of QI-1 enrollee(s) and Return Date.

If the individual does not return the Renewal Form, the district must close or delete the individual using Reason Codes F10 ("Failure to return recertification form") or U20 ("Verification of factors which affect eligibility. Unable to get information but not good cause"), whichever is appropriate. The local district must also delete the individual from the Buy-In file in eMedNY.

Although the initial run of these notices will be on December 10, 2005, subsequent runs will be done around June 1st of each year.

CNS Paragraph Form

Date: 11.03.05

Program Area	**03**	**(01=PA, 02=FS, 03=MA, 04=HP)**
Paragraph Number	**R0043**	
Version Number	**00001**	
Effective Date	**2005**	**(YYMMDD)**
Title	**Notice of Renewal (Recertification) for QI1 (Upstate and Downstate)**	
Comment		
Reason Code		

During the previous year, you or a member of your household was eligible to have the Medical Assistance Program pay the Medicare Part B premium.

This letter is to tell you that you must complete and return the enclosed "Medicare Savings Program Re-enrollment Form" to help us determine if you or a member of your household can still have the Medical Assistance Program pay your Medicare Part B premium.

You or your authorized representative must complete and return the enclosed form and requested documentation to the following address by (insert date):

Requested Documentation: Send copies of all documentation that applies to you (and your spouse, if married). You must submit proof of current income and other changes that have occurred to you (and your spouse, if married) since your last re(certification).

If you or your representative needs help completing the form or getting the documentation, please call the above worker telephone number as soon as possible.

If you or your representative does not return the form and/or the requested documentation by the above date, we will think that you do not want the Medical Assistance Program to pay your Medicare Part B premium and will close your case. Before closing your case, we will send you a notice telling you the closing date.

CNS Paragraph Form

Date: 11.28.05

Program Area	**03**	**(01=PA, 02=FS, 03=MA, 04=HP)**
Paragraph Number	**R9005**	
Version Number	**0001**	
Effective Date	**2005**	**(YYMMDD)**
Title	**QI-1 Re-Enrollment Form**	
Comment		
Reason Code		

PLEASE COMPLETE, SIGN, AND RETURN THIS FORM TO CONTINUE YOUR PARTICIPATION IN THE MEDICARE SAVINGS PROGRAM.
FAILURE TO RETURN THIS FORM MAY CAUSE PAYMENT OF YOUR PREMIUM TO END

□ Married □ Single CIN# Social Security Number _____
Has your marital status changed since you originally applied for this program? □Yes □No
If Yes, how has it changed? _____
Do you or your spouse pay any health insurance premiums other than Medicare?

Yes_____ No_____ Monthly Amount $_____

MONTHLY INCOME

- *If you are married, report the joint income for you and your spouse*
- *Fill in each line. Where you do not have income, check the* NONE *box.*
- *Report all income including Social Security, pensions, interest from savings, rental income, etc.*

	YOUR INCOME	**NONE**	**SPOUSE'S INCOME**	**NONE**
1. Social Security and/or Railroad Retirement Benefits	$_____	□	$_____	□
2. Pensions and Annuities	$_____	□	$_____	□
3. Earned income (wages, business income, self employment income)	$_____	□	$_____	□
4. Other income (IRA, rental income, Capital gains, Etc.)	$_____	□	$_____	□
5. Interest and dividends	$_____	□	$_____	□
TOTAL MONTHLY INCOME	**$_____**		**$_____**	

CONSENT: I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for help paying my Medicare premium. If additional information is requested, I will provide it.

Applicant/Representative Signature_____ Date_____