George E. Pataki
Governor

NEW YORK STATE
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
40 NORTH PEARL STREET
ALBANY, NY 12243-0001

Robert Doar
Commissioner

Informational Letter

Section 1

Transmittal:	06-INF-15
To:	Local District Commissioners
Issuing Division/Office:	Division of Program Support and Quality Improvement
Date:	April 11, 2006
Subject:	Revisions to the LDSS-3174 Recertification Form for Temporary Assistance, Medical Assistance, Medicare Savings Program and Food Stamp Benefits and Pub-1313 How to Complete the LDSS-3174
Suggested Distribution:	Temporary Assistance Staff Food Stamp Benefits Staff Medicaid Staff CAP Coordinators Employment Coordinators WMS Coordinators Services Coordinators Staff Development Coordinators Forms Coordinators
Contact Person(s):	Forms Questions: Jacqueline Brace, Document Services and Operational Support: (518) 474-9522 Program Questions: Medicaid: Local District Support Liaison, Upstate (518) 474-8887; NYC (212) 417-4500 Temporary Assistance Bureau: (518) 474-9344 Food Stamp Benefits Bureau: (518) 473-1469 Welfare to Work Bureau: (518) 402-3198 HEAP Bureau: (518) 473-0332 Metro Region: (212) 961-8207 WMS Bureau: (518) 474-8749
Attachments:	Attachment 1 - LDSS-3174 (Rev. 5/05) Attachment 2 - Pub-1313 (Rev. 5/05)
Attachment Available On – Line:	☒

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
85 ADM-38 89 INF-53 95 INF-8 95 INF-29 96 INF-26 01 INF-22 03-INF-26	95 INF-29 95 INF-8	350.4 351.21 360.1 369.1 369.4 387.6 387.17 404.1		PASB Chapter 6 FSSB Section 4; Section 6 MRG p.364	95 ADM-1

Section 2

I. Purpose

The purpose of this release is to inform local districts that the following forms have been revised (copies attached):

- LDSS-3174 (Rev. 5/05)
- Pub-1313 (Rev. 5/05)

II. Forms Revisions:

LDSS – 3174

PAGE 1:

1. The revision date was **changed** to 5/05.

2. A one-character field was **added** after the "Case Name" field in the shaded worker data entry section at the top of the page.

   This field is labeled "LIFELINE" and is driven by the answer given to the question that was added to Page 16 of the Recertification Form.

3. "I REQUEST THAT MY CASE BE CLOSED…" was **moved** to page 13. This was done to assure that a recipient discusses the decision to request that his/her case be closed with a worker. During the discussion, the worker can explain what transitional programs the recipient may be eligible for.

4. The statement concerning self-sufficiency implied that work activities are required for all programs listed. There are no work requirements for Medicaid, other than for MBI-WPD. The second sentence in the statement was **changed** to read ..."including work activities for Temporary Assistance and Food Stamp Benefits where required."

SECTION 3

5. The title "**Recertification Information**" was **changed** to "**Recipient Information**" in the shaded gray area directly below the "Do You Want To Receive Notices In" section.

PAGE 2:

The revision date was **changed** to 5/05.

PAGE 3:

1. The revision date was **changed** to 5/05.

SECTION 6

2. In the "**RACE/ETHNIC AFFILIATION CODES"**, "**H** Hispanic or Latino (a)" was **changed** to "**H** Hispanic or Latino".

3. In the listing of "**RACE/ETHNIC AFFILIATION CODES",** an additional code was **added** directly below the "**W**" White code. The new code is labeled "U Unknown **(MA** Only**)**".

4. An additional "**RACE/ETHNIC AFFILIATION CODES**" column was **added** in the "**RACE AFFILIATION**" section, to the right of the "**W**" column. That additional column is labeled "**U**".

5. The "**ALIEN INFORMATION**" section title was **changed** to "**IMMIGRATION INFORMATION**" in the shaded worker's section at the bottom of the page.

6. The “ALIEN STATUS” column title was **changed** to “IMMIGRATION STATUS” at the bottom of the page in the shaded gray area next to the “LN” column.

7. The “Documentation” reference, “Alien Status” was **changed** to “Immigration Status” in the shaded gray area on the bottom of this page.

PAGE 4:

1. All of the “Alien” references in SECTIONS 9 and 10 were **changed** to “Immigrant” with the exception of the ‘ALIEN NUMBER’ column title in section “9”.

SECTION 9

2. The Revision Date wa**s changed** to 5/05.

3. “Or” was **deleted** from the end of the first bullet.

4. The second bullet was **changed** to read:

   “You are not a U. S. citizen, Native American or national of the United States or an immigrant with satisfactory immigration status. The term ‘satisfactory immigration status’ means an immigration status which does not make the individual ineligible for benefits under the applicable program.

5. **"If you are a Native American, check ‘CITIZEN/NATIONAL’."** was **added** as the last sentence in the second box.

6. The column entitled "Check either ‘CITIZEN/ NATIONAL’ OR ‘ALIEN’ for each person" was changed to "Check either ‘CITIZEN / NATIONAL’ or ‘IMMIGRANT’ for each person.”

SECTION 10

7. The first two paragraphs were **changed** to read as they do in the LDSS-2921:

   "Some social services programs require that you certify that you are a U.S. citizen, Native American or national of the United States, or an immigrant with satisfactory immigration status. Other programs do not. If you are an immigrant and do not know if you have satisfactory immigration status, see the "How To Complete" instruction book or talk to your worker.

   You MUST sign the Certification below only if you are a U.S. citizen, Native American or national of the United States, or an immigrant with satisfactory immigration status, **and** you are recertifying for:"

8. The fifth bullet, "Other services..." was **deleted**.

9. The first certification instruction box at the bottom of the page was **changed** to read, “…am a United States citizen, Native American or national of the United States, or an immigrant with satisfactory immigration status.”

10. In the second certification instruction box at the bottom of the page, "**Immigration and Naturalization Service (INS)**” was **changed** to "**United States Citizenship and Immigration Services (USCIS)**".

PAGE 5:

The Revision Date was **changed** to 5/05.

PAGE 6

1. The Revision Date was **changed** to 5/05.

SECTION 15

2. The shading was **removed** from the "OTHER INCOME" section of the "INCOME INFORMATION" column.

3. The "CD" column in the shaded worker area to the right of the "INCOME INFORMATION" column was removed because the recertification form is now a Statewide form and the codes that were listed in that column were only applicable to Upstate districts.

SECTION 16

4. 1. The title 'Step-Parent /Alien Sponsor Information' section title was changed to 'Step-Parent /Immigrant Sponsor Information' and the 'Alien' reference was changed to "Immigrant" in the question below the title.

5. In the "CONSIDER" cues, a check mark and the consider cue, "Refugee Matched Grants" were added.

PAGE 7:

1. The revision date was **changed** to 5/05.

SECTION 17

2. The third box was changed to read:

"Is health insurance available through your employer? ☐ Yes ☐ No.

Does anyone else have health insurance through their employer? ☐ Yes ☐ No.

Who: _____

Name of Insurance Company: _____"

PAGE 8:

1. The revision date was **changed** to 5/05.

SECTION 18

2. The statement, "For your children under 16, list their names and what schools they attend:" was changed to:

"Is under 16 years of age and is attending School? ☐ Yes ☐ No."

PAGE 9:

1. The revision date was **changed** to 5/05.

SECTION 19

2. In the "**DOCUMENTATION**" cue section, "Car/Vehicle Registration" was **changed** to "Car/Vehicle Registration (older models)".

3. In the shaded gray area at the bottom of the page, the "$" symbol was **added** on both lines of the "NADA" section.

PAGE 10:

1. The revision date was **changed** to 5/05.

SECTION 20

2. The following two questions were **added:**

   "Is on Medicaid with a spenddown"

   "Has health Insurance available through your employer"

3. The question "Is pregnant**, IF PREGNANT, PLEASE GIVE DUE DATE:** _____" was **reformatted** to extend into the gray area.

4. Because additional questions were added to Section "20", the red reference numbers were **adjusted** accordingly.

5. The "**HEALTH PLAN SELECTION**" section from page 10 of the LDSS-2921 was added.

PAGE 11:

1. The revision date was changed to 5/05.

SECTION 21

2. The "**SHELTER**" information was **revised** to mirror the "**SHELTER**" Information on the recently revised LDSS-2921: Application, along with and including some of the following changes:

   a. The telephone related information on this page was **eliminated** because the language in the Standard Utility Allowance (SUA) statement, on page 16, now addresses FS recipients' eligibility for a phone allowance.

   b. A new column was **added** to the right of the "MONTHLY EXPENSES" column at the bottom of the page, in the shaded gray worker's area.

      The new column is titled, "**MONTHLY ACTUAL COST**".

   c. The "**VENDOR**" column title was **changed** to "**NAME OF DEALER**".

   d. In the "SHELTER COSTS" column, section "E" was **changed** from "E. Utility/Phone Installation Fees" **to** "E. Utility Installation Fees"

   e. The "MONTHLY EXPENSES" column, in the shaded gray area, was **changed** to eliminate the "Telephone Expense" and "Utility/Telephone Installation Fees" was **changed** to "Utility Installation Fees".

   f. In the "**CONSIDER**" section, "Life Line" was **changed** to "Lifeline".

g. A new last "**CONSIDER**" check mark and statement were **added**. That new "**CONSIDER**" reads:

If Shelter Expenses/Living Quarters Are Shared By More than One Household" was added.

PAGE 12:

1. The revision date was **changed** to 5/05.

SECTION 23

2. Under "**OTHER INFORMATION (CONT.)"**, "applying" was changed to "recertifying" in the first box.

PAGE 13:

1. The revision date was **changed** to 5/05.

2. "I REQUEST THAT MY CASE BE CLOSED…" was **moved** from page 1 to page 13. This was done to assure that a recipient discusses the decision to request that his/her case be closed with a worker. During the discussion, the worker can explain what transitional programs the recipient may be eligible for.

3. The "Notes/Comments" section was **moved** lower on the page.

Pages 14 through 16: 'READ THE IMPORTANT INFORMATION BELOW' also known as the "legal" section, were revised to mirror the same information as on the LDSS-2921: Application, where appropriate.

PAGE 14:

1. The revision date was **changed** to 5/05.

SECTION 25

2. The title of the "**FOOD STAMPS AUTHORIZED REPRESENTATIVE**" was **changed** to "**FOOD STAMP BENEFITS AUTHORIZED REPRESENTATIVE**".

3. The "**FOOD STAMP BENEFITS AUTHORIZED REPRESENTATIVE**" was **changed** to read:

FOOD STAMPS BENEFITS AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to **apply** for Food Stamp Benefits (FS) for you. You can also authorize someone outside your household to get FS for you and to use them to buy food for you. If you would like to authorize someone, print the person's name, address and phone number directly below.

When an Authorized Representative is applying on behalf of a Food Stamp Benefits Household that does not reside in an institution, **both** the Authorized Representative and the Food Stamp Benefits Head of Household must sign and date the signature sections at the bottom of page 16.

PAGE 15:

1. The revision date was **changed** to 5/05.

SECTION 27

2. The first paragraph of the 'CHANGES' subsection was **changed** to read:

CHANGES - I agree to inform the agency **promptly** of any changes, to the best of my

knowledge and belief, including, but not limited to, any change in my needs, residency/address, living arrangements, household size, income, employment, property/resources, dependent care costs, health insurance, immigration/citizenship status or pregnancy.

If I am applying for child care assistance, I agree to inform the agency **immediately** of any change in family income, who lives in my house, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit."

PAGE 16:

1. The revision date was **changed** to 5/05.

2. The "Lifeline" information was **revised**.

   That new "Lifeline" language reads:

   "**LIFELINE** - For applicants/recipients of temporary assistance and/or food stamp benefits: The Office of Temporary and Disability Assistance may or may not release your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate.

   If you *do not* want this information released, check this box ☐.

   You may contact your telephone service provider directly for enrollment in the discounted rate Lifeline Service."

   Medicaid-**only** applicants/recipients must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service."

SECTION 28

3. The "Authorization For Reimbursement Of Public Assistance Benefits From SSI Retroactive Payment" information was **changed** to read:

   "**AUTHORIZATION FOR REIMBURSEMENT OF PUBLIC ASSISTANCE BENEFITS FROM SSI RETROACTIVE PAYMENT-** I authorize the Commissioner of the Social Security Administration (SSA) to send to the local social services district the amount that is due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if my SSI benefits are terminated or suspended and are later reinstated.

   I understand that the local social services district may take from my retroactive SSI payment the amount of Public Assistance (except assistance paid wholly or partly with federal funds) that it paid to me during the period that begins (1) with the first day I became eligible for payment of SSI benefits or (2) the first day to which SSI benefits were reinstated after a period of suspension or termination and ends with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments resume).

   After taking this money from my SSI check(s), the local social services district will pay me the balance, if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as Public Assistance, I will be given an opportunity for a hearing.

   I understand that:

- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.

- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement. It will not have any effect on cases that have been completely decided or if the SSA has already made an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I have mutually agreed to terminate the authorization.

  This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon new SSI applications made after that date."

SECTION 29

4. The "Applicant/Representative Signature" title at the bottom of the page was **changed** to "Applicant Signature".

5. New "Authorized Representative Signature" and "Date" boxes were **added** to directly below the "Applicant Signature" and "Date" boxes at the bottom of this page.

***VOTER* REGISTRATION FORM PAGE:**

The instructions for "How to Complete" the Voter Registration form were **added**.

PUB-1313:

PAGE 1:

1. The Revision Date was **changed** to 5/05.

2. A new 5th Bullet was **added**, that reads:

   IF YOU HAVE ANY DISABILITIES, WHICH PREVENT YOU FROM COMPLETING THIS RECERTIFICATION FORM AND/OR WAITING TO BE INTERVIEWED, PLEASE NOTIFY THE RECEPTIONIST. THE AGENCY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATION TO ADDRESS YOUR NEEDS.

3. The "WITHDRAWAL" statement was **replaced** with the following statement:

   "**DISCONTINUE:** IF YOU WANT TO STOP GETTING ASSISTANCE, TALK TO YOUR ELIGIBILITY EXAMINER."

3. The Spanish note at the bottom of the page was **removed**.

PAGE 2:

1. The Revision Date was **changed** to 5/05.

SECTION 1

2. This section was **changed** to read:

   "Check ( ) the box for EACH program that you or any household member wants to recertify for. Because of welfare reform, a recertification for Temporary Assistance is no longer automatically

a recertification for Medical Assistance. If you want to recertify for both Temporary Assistance and Medical Assistance, check ( ) the Temporary Assistance and Medical Assistance box. If you want to recertify for the Medicare Savings Program check, ( ) the Medicare Savings Program box. Medical Assistance includes the Medicaid, Family Health Plus, Child Health Plus A, Medicaid Buy-In for Working People With Disabilities and Family Planning Benefit programs. If you want to recertify for any of these programs, check ( ) the Medical Assistance box.

If you are recertifying for Temporary Assistance and Food Stamp Benefits, and/or Medical Assistance, usually you will be required to have only a single interview for all programs. If you are recertifying for Medical Assistance only, you do not have to have an interview."

SECTION 3

3. The following was **added**, directly above "NAME":

   RECIPIENT INFORMATION

4. Also, on the "**CARE OF NAME**" line, the information after the comma was **changed** to read:

   PRINT that person's name.

PAGE 3:

1. The Revision Date was **changed** to 5/05.

SECTION 6

2. Under the fourth bullet the third sub-bullet beginning, "An alien who is"..., was **deleted.**

3. In the fifth bullet, the portion of the statement about the "Highest School Grade Completed", was **changed** from "If more than 12 years, enter 12" to "If more than 12 years, enter 13".

PAGE 4:

1. The Revision Date was **changed** to 5/05.

2. In the 'Race/Ethnic Affiliation' section, 'Latino (a)' was **changed** to 'Latino'.

SECTION 9

3. The title for section "9" was **changed** to:

   CITIZENSHIP/IMMIGRATION STATUS INFORMATION

4. The second bullet, "You are recertifying only for coverage for the treatment of an emergency medical condition, or" was **deleted**.

5. The first sentence of the third bullet, which is now the second bullet, was **changed** to read:

   "You are *not* a U. S. citizen, Native American or national of the United States *or* an immigrant with satisfactory immigration status. 'Satisfactory immigration status' is an immigration status which does not make the individual ineligible for benefits under the applicable program."

SECTION 10

6. The title for section "10" was **changed** to:

   "**CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS INFORMATION**"

7. The first sentence of the 2nd bullet in the 'CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS INFORMATION' was **changed** to read:

   ● You are not a **U.S. citizen**, **Native American or national of the United States** *or* **an immigrant with satisfactory immigration status**.

PAGE 5:

1. The Revision Date was **changed** to 5/05.

2. The title for the continuation of section "10" was **changed** to:

   "CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS INFORMATION (continued)"

3. The lead in, for the first "**NOTE**", directly below the title, was **changed** to read:

   "**NOTE:** You **MUST** sign this certification if you are a **U.S. citizen, Native American** or **national of the United States,** or **an immigrant with satisfactory immigration status,** and you are recertifying for:"

4. The last two sentences before the "**NOTICE**" were **changed** to read as follows:

   "A *parent* without satisfactory immigration status may sign for his/her child who has satisfactory immigration status. **For example**, a mother who does not have satisfactory immigration status may still sign the certification for her children who are U.S. citizens."

5. The **NOTICE** section was **changed** to read:

   NOTICE

   "You should not sign this declaration for yourself or for another person who is not a U.S citizen, Native American or national of the United States or an immigrant with satisfactory immigration status. Noncitizens without satisfactory immigration status are not eligible for any Temporary Assistance, Food Stamp Benefits or Medical Assistance benefits (except Medical Assistance for a pregnant person or Medical Assistance coverage ONLY for treatment of an emergency medical condition). Such persons may also be ineligible for certain Services.

   We may confirm the immigration status of any or all household members recertifying for Temporary Assistance, Medical Assistance benefits, Food Stamp Benefits or Services by submitting the information you give us to the United States Citizenship and Immigration Services (USCIS). Information received from the USCIS may affect your household's eligibility and level of benefits."

SECTION 11

6. In the "**NON-CUSTODIAL PAERNT/CHILD SUPPORT/MEDICAL SUPPORT INFORMATION**" of section "11", another sentence was **added** to the end of the Medical Assistance note. That new sentence reads:

   "If you want to pursue medical support from a non-custodial parent, you must complete this section."

PAGE 6:

1. The Revision Date was **changed** to 5/05.

SECTION 15

2. The “Foster Care Payments” and “Food Stamp Benefits” note was **changed** to read:

   “NOTE: Foster Care Payments and Food Stamp Benefits –You may choose to include the foster care child or adult in the Food Stamp Benefits household. If you do, any associated foster care payments will **not** be counted as income. All other income or resources of the foster care child will be counted. If you have any questions about this, make sure to ask your worker.”

SECTION 16

3. The title was **changed** to “**STEP-PARENT/IMMIGRANT SPONSOR INFORMATION**”.

PAGE 7:

1. The Revision Date was **changed** to 5/05.

SECTION 19

2. In the last sentence of the first paragraph "or guardians” was **deleted**.

SECTION 20

3. The "**HEALTH PLAN SELECTION**" information was **added** as it is on the LDSS-2921.

PAGE 8:

1. The Revision Date was **changed** to 5/05.

SECTION 21

2. The instruction, “Be sure to check ( ) primary heat type at bottom of this page was **removed** from section “21” because this is a worker’s instruction.

SECTION 22

3. The word "Information" was **deleted** from the "Other Expenses Information" title. The revised title now reads, "Other Expenses".

SECTION 23

4. The following statement was **added** for the purpose of clarifying the meaning of “U.S. Military” service.

   “‘U.S. Military’ also includes Reservists or National Guard members who have ever been called to active duty by the President of the United States.”

5. Under ‘PAGE 13 OF THE RECERTIFICATION FORM’ the following paragraph was added:

   “**DO NOT WRITE ON THIS PAGE UNLESS YOU WANT TO CLOSE YOUR CASE FOR ONE OR MORE OF THE PROGRAMS LISTED IN THE TOP RIGHT HAND CORNER OF PAGE 13 OF THE RECERTIFICATION FORM. TO CLOSE YOUR CASE FOR A PROGRAM, PUT A CHECKMARK ( ) IN THE BOX NEXT TO THAT PROGRAM AND SIGN WHERE INDICATED. YOUR CASE WILL ONLY BE CLOSED FOR THE PROGRAM(S) YOU CHECK. BEFORE ASKING FOR YOUR CASE TO BE CLOSED, TALK TO YOUR WORKER. YOU MAY BE ELIGIBLE FOR TRANSITIONAL HELP**.”

PAGE 9:

1. The Revision Date was **changed** to 5/05.

SECTION 26

2. The title was **changed** to:

   "**PENALTIES/FOOD STAMP BENEFITS (FS) PENALTY WARNING."**

SECTION 27

3. The title was **changed** to:

   "**ASSIGNMENTS, AUTHORIZATIONS & CONSENTS."**

4. The "Lifeline" instructional information in the **"ASSIGNMENTS, AUTHORIZATIONS & CONSENTS"** was **changed** to read:

   "**NOTE**: For **Lifeline**, Temporary Assistance and Food Stamp applicants/recipients must check (√) the box, if you ***do not*** authorize the NYS Office of Temporary and Disability Assistance to possibly disclose your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate. Lifeline is the lowest rate available for basic telephone service from telephone service providers."

   Medicaid-**only** applicants/recipients must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service.

SECTION 29

5. The reference to "Recertification" was **changed** to "Recertification Form" in the 2nd sentence of the 2nd paragraph.

6. In the "signature" area, an additional sentence was **added** after the 3rd sentence that reads:

   "If you are a Food Stamp Benefits Authorized Representative, both you and the applicant must sign and date the signature sections on the bottom of page 16 of the Recertification Form."

7. The last line, "All persons 18 years of age or older must sign." was deleted.

PAGE 10:

1. The Revision Date was **changed** to 5/05.

2. The 'NOTICE' which provides information concerning the right to a "Fair Hearing" was reformatted. The telephone number, internet address and fax number used to request a "fair hearing" were added.

3. The second box was **revised** to specify that the Social Services programs are Temporary Assistance, Food Stamps Benefits, Medical Assistance, and Medicare Savings programs.

VI. Additional Information:

Because these documents provide current program and policy information as well as mandated legal information, comments on the format and content of these forms and publications are always welcome. Comments received will be pended and considered at the next printing of these forms. Comments may be forwarded to:

Ms. Jacqueline Brace
Document Services and Operational Support
93 Broadway
Menands, New York 12204
Jacqueline.Brace@otda.state.ny.us

Comments relating to Medicaid policy should be directed to the district's Local District Support Liaison, as indicated on page one."

IV. Forms Ordering Information:

- The revised 5/05 versions of the LDSS-3174 and Pub-1313 are stocked in the Albany and NYC Warehouses. Your district has automatically received copies. Any previous versions must be destroyed.

- The other than English versions of the LDSS-3174 and Pub-1313 will be translated shortly and we expect that they will be available for ordering sometime in May 2006.

- Any future requests for printed copies of the 5/05 versions of the LDSS-3174 and Pub-1313 should be submitted on an OTDA-876 "Request For Forms or Publications" and should be sent to:

  Office of Temporary and Disability Assistance
  BMS Document Services and Operational Support
  P.O. Box 1990
  Albany, New York 12201

  Questions concerning ordering forms should be directed to BMS Document Services and Operational Support at 1-800-343-8859, ext. 4-9522.

- Documents also may be ordered through Outlook. To order the forms you must obtain an OTDA-876 electronically by going to the OTDA Intranet Website at http://otda.state.nyenet/ then to Division of Program Support & Quality Improvement page, then to PSQI E-Forms page (this page contains the electronic OTDA-876).

- For those who do not have Outlook but who have Internet access for sending and receiving email, the Internet email address is: gg7359@dfa.state.ny.us. For a complete list of available forms, please refer to OTDA Intranet site: http://otda.state.nyenet/ldss_eforms/default.htm .

Issued By _____
Name: John Paolucci
Title: Deputy Commissioner
Division/Office: Division of Program Support & Quality Improvement

DO NOT WRITE IN THE SHADED AREAS OF THIS RECERTIFICATION FORM

CENTER/ OFFICE	INTERVIEW DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NUMBER	DISTRICT	CATEGORY	LANG	NUMBER REUSE INDICATOR

CASE NAME	LIFELINE	EFFECTIVE DATE	DISPOSITION
			☐ RECERTIFICATION ☐ CLOSE ☐☐☐ REASON CODE

ELIGIBILITY DETERMINED BY (WORKER):	DATE	ELIGIBILITY APPROVED BY (SUPERVISOR):	DATE	FORM _____ 0F _____	SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION X _____	DATE

DATE RECEIVED BY AGENCY

EMPLOYED BY: SOCIAL SERVICES DISTRICT PROVIDER AGENCY SPECIFY: _____

TA AUTHORIZATION PERIOD		MA AUTHORIZATION PERIOD		FS AUTHORIZATION PERIOD	
FROM	TO	FROM	TO	FROM	TO

NEW YORK STATE

RECERTIFICATION FORM FOR: TEMPORARY ASSISTANCE (TA) - MEDICAL ASSISTANCE (MA) – MEDICARE SAVINGS PROGRAM (MSP) - FOOD STAMP BENEFITS (FS)

We are committed to assisting and supporting you in a professional and respectful manner with your goal of achieving self-sufficiency. You, in turn, must be committed to becoming self-sufficient and must be responsible for participating in activities to reach self-sufficiency including work activities for Temporary Assistance and Food Stamp Benefits where required. Whenever you see "Temporary Assistance" or "TA" on the recertification form, it means "Family Assistance" and "Safety Net Assistance". We call both Public Assistance Programs "Temporary Assistance". These TA Programs are meant to assist you only until you can fully support yourself and your family.

Please refer to the "How to Complete" instruction book (Pub-1313 Statewide) when completing this recertification form.

CHECK EACH PROGRAM YOU OR ANY HOUSEHOLD MEMBER WANTS TO RECERTIFY FOR

☐ **Temporary Assistance and Medical Assistance** ☐ **Temporary Assistance** ☐ **Medical Assistance**

☐ **Medicare Savings Program** ☐ **Food Stamp Benefits**

1

DO YOU WANT TO RECEIVE NOTICES IN: ☐ SPANISH AND ENGLISH ☐ ENGLISH ONLY

WHAT IS YOUR PRIMARY LANGUAGE? ☐ ENGLISH ☐ SPANISH ☐ OTHER (specify) _____

2

RECIPIENT INFORMATION — PLEASE PRINT CLEARLY

FIRST NAME	M.I.	LAST NAME	MARITAL STATUS	PHONE NUMBER ( ) AREA CODE

HOUSE NO.	STREET ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

3

CARE OF NAME (Complete if you receive your mail in care of another person)

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

AGENCY HELPING RECIPIENT/CONTACT PERSON	PHONE NUMBER ( ) AREA CODE

HOW LONG HAVE YOU LIVED AT YOUR PRESENT ADDRESS?	YEARS	MONTHS	IS THIS A SHELTER? ☐ YES ☐ NO	ANOTHER PHONE WHERE YOU CAN BE REACHED	NAME	PHONE NUMBER ( ) AREA CODE

DIRECTIONS TO HOME

FORMER ADDRESS	APT. NO.	CITY	COUNTY	STATE	ZIP CODE

List the things that have changed since your application or last recertification (such as moved, had a baby, income, etc.) _____

If You Are Reapplying For Food Stamp Benefits (FS), you have the right to turn in (file) this form the same day you get it. It must have at least your Name, Address (if you have one) and Signature below when you turn it in. If you are eligible, you will get FS back to the date you filed. You may be able to get FS quicker if you have little or no income or liquid resources, or if your rent and utility expenses are more than your income and liquid resources. Talk to your worker if you have questions about this.

4

FS RECIPIENT/REPRESENTATIVE SIGNATURE	DATE SIGNED

DO ANY OF THESE APPLY TO YOU?

5

- ☐ Pregnant 1
- ☐ Victim Of Domestic Violence 2
- ☐ Need To Establish Paternity 3
- ☐ Need Child Support 4
- ☐ Drug/Alcohol Problem 5
- ☐ Fuel Or Utility Shutoff 6
- ☐ No Place To Stay/Homeless 7
- ☐ Urgent Personal Or Family Problem 8
- ☐ Fire Or Other Disaster 9
- ☐ Have No Job 10
- ☐ Serious Medical Problem 11
- ☐ Recently Lost Income 12
- ☐ Pending Eviction 13
- ☐ No Food 14
- ☐ Need Foster Care 15
- ☐ Need Child Care 16
- ☐ Other _____ 17

LIST EVERYBODY WHO LIVES WITH YOU, EVEN IF THEY ARE NOT RECERTIFYING WITH YOU. LIST YOURSELF ON THE FIRST LINE. *PLEASE PRINT.*

DOES THIS PERSON (INCLUDING YOUR MINOR CHILDREN) BUY FOOD OR PREPARE MEALS WITH YOU?

HIGHEST SCHOOL GRADE COMPLETED

RI	LN	FIRST NAME	(Middle Initial) M.I.	LAST NAME	THIS PERSON IS RECERTIFYING FOR: TA	FS	MA	MSP	DATE OF BIRTH Month	Day	Year	SEX M OR F	RELATIONSHIP TO YOU	SOCIAL SECURITY NUMBER OF RECERTIFYING MEMBERS *(See "How to Complete" instruction book Pub-1313 Statewide, **or** talk to your worker)*		YES	NO
	01												**SELF**				
	02																
	03																
	04																
	05																
	06																
	07																
	08																

6

PLEASE LIST MAIDEN OR OTHER NAMES BY WHICH YOU OR ANYONE IN YOUR HOUSEHOLD HAS BEEN KNOWN

Line No.	ONC	FIRST NAME	M.I.	LAST NAME
Line No.	ONC	FIRST NAME	M.I.	LAST NAME

7

DO NOT WRITE IN SHADED AREAS

HAS ANYONE MOVED **INTO** THE HOUSEHOLD IN THE PAST YEAR? ☐ YES ☐ NO

IF YES, INDICATE BELOW.

DID THEY EVER LIVE IN NEW YORK STATE BEFORE NOW?

HAS ANYONE MOVED **OUT** OF THE HOUSEHOLD IN THE LAST YEAR? ☐ YES ☐ NO

IF YES, INDICATE BELOW.

NAME	☐ YES ☐ NO	NAME	WHEN?
NAME	☐ YES ☐ NO	NAME	WHEN?

8

IS ANYONE SANCTIONED? ☐ YES ☐ NO	IF YES, WHO	REASON	END DATE

NON-APPLICANT INFORMATION

LN	FIRST NAME	LAST NAME	LEGALLY RESPONSIBLE YES	NO	FOR WHOM?	CONTRIBUTION/ DEEMED INCOME	CHECK IF MEMBER OF FS HOUSEHOLD

INDIVIDUAL EDUCATION

LN	DEGREE RECEIVED	LN	DEGREE RECEIVED	LN	DEGREE RECEIVED	LN	DEGREE RECEIVED
01		03		05		07	
02		04		06		08	

RACE/ETHNIC AFFILIATION CODES

H Hispanic or Latino
I Native American or Alaskan Native
A Asian
B Black or African American
P Native Hawaiian or Pacific Islander
W White
U Unknown (**MA** Only)

LN	ENTER Y (YES) OR N (NO) IF HISPANIC OR LATINO	ENTER Y (YES) OR N (NO) FOR EACH RACE AFFILIATION					
	H	I	A	B	P	W	U
01							
02							
03				6			
04							
05							
06							
07							
08							

ANTICIPATED FUTURE ACTION

LINE NO.	CODE	DATE

CASE TYPE	RELATED CASE NUMBERS

CONSIDER

- ✓ Relationship
- ✓ Filing Unit
- ✓ Legally Responsible Relative
- ✓ Single Economic Unit
- ✓ FS Household Composition
- ✓ FS Aged/Disabled Individual
- ✓ Photo ID/AFIS
- ✓ CBIC/PIN
- ✓ RFI/OCA
- ✓ Health Insurance
- ✓ Child Support Pass-Through

NEEDED	REFERRALS	COMPLETED
	CAP	
	SSA	
	Legal	

REQUESTED	DOCUMENTATION	IN FILE
	Photo I.D.	
	Birth Verification	
	Marriage License	
	Social Security Card	
	Code 9 Resolution	
	Immigration Status	
	Multi-Suffix/Co-op Case Notice (Single Economic Unit Questionnaire)	

IMMIGRATION INFORMATION

LN	IMMIGRATION STATUS	STATUS ADJUSTED		DATE OF ENTRY/STATUS			APPLIED FOR CITIZENSHIP		SPONSORED	
		YES	NO	MO	DAY	YEAR	YES	NO	YES	NO

CITIZENSHIP/IMMIGRATION STATUS INFORMATION

Please read the entire page carefully before completing. If you have questions, see the "How to Complete" instruction book or talk to your worker.

SECTION 9

LIST EVERYONE WHO IS RECERTIFYING OR WHO IS REQUIRED TO RECERTIFY.

IF YOU HAVE QUESTIONS, SEE THE "HOW TO COMPLETE" INSTRUCTION BOOK (PUB-1313 Statewide) OR TALK TO YOUR WORKER.

You **do not** have to fill out Section 9 or 10 if you are recertifying for MA **only** and:

- you are pregnant
- you are not a U. S. citizen, Native American or national of the United States or an immigrant with satisfactory immigration status. The term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program.

You **do** have to fill out Section 9 or 10 if you are:

- recertifying for MA **only,** but you do not have to include people who do not want MA.

SECTION 10 - CERTIFICATION

Some social services programs require that you certify that you are a U.S. citizen, Native American or national of the United States, or an immigrant with satisfactory immigration status. Other programs do not. If you are an immigrant and do not know if you have satisfactory immigration status, see the "How To Complete" instruction book or talk to your worker.

You MUST sign the Certification below only if you are a U.S. citizen, Native American or national of the United States, or an immigrant with satisfactory immigration status, **and** you are recertifying for:

- Temporary Assistance (where there are children in the household or a member of the household is pregnant), or
- Food Stamp Benefits, or
- Medical Assistance (except if the recipient is pregnant), or
- Medicare Savings Program

An adult household member or authorized representative may sign for all household members. Example: A *parent* without satisfactory status may sign for his/her *child* who has satisfactory status.

A recertification for FS must list all persons living in the FS household. A recertification for TA must list all children for whom you are recertifying, their brothers and sisters and all parents of those children who live together. If you do not check whether a listed person is a U. S. citizen or national, or an immigrant, or provide an alien number for an immigrant, that person will not be given assistance, and the remaining members of the household will receive reduced benefits. If you are a Native American, check "CITIZEN/NATIONAL".

SIGN* AND DATE THE BOX BELOW FOR EACH RECIPIENT.

IN THE CASE OF A RECERTIFYING IMMIGRANT, CHECK (✓) THE PROGRAM(S) FOR WHICH EACH RECERTIFYING IMMIGRANT HAS SATISFACTORY IMMIGRATION STATUS. (SEE "HOW TO COMPLETE" INSTRUCTION BOOK, PUB-1313 STATEWIDE.)

LN	FIRST NAME	MI	LAST NAME	Check **either "CITIZEN/ NATIONAL" or "IMMIGRANT" for** each person.		***Alien Number (If Applicable)***	**CERTIFICATION**	Date	TA	FS	MA	MSP
01				☐ CITIZEN/ NATIONAL	☐ IMMIGRANT	A	Sign Name X					
02				☐ CITIZEN/ NATIONAL	☐ IMMIGRANT	A	Sign Name X					
03			9	☐ CITIZEN/ NATIONAL	☐ IMMIGRANT	A	Sign Name X	10				
04				☐ CITIZEN/ NATIONAL	☐ IMMIGRANT	A	Sign Name X					
05				☐ CITIZEN/ NATIONAL	☐ IMMIGRANT	A	Sign Name X					
06				☐ CITIZEN/ NATIONAL	☐ IMMIGRANT	A	Sign Name X					
07				☐ CITIZEN/ NATIONAL	☐ IMMIGRANT	A	Sign Name X					
08				☐ CITIZEN/ NATIONAL	☐ IMMIGRANT	A	Sign Name X					

By checking a box above and by signing the certification in Section 10, I hereby certify, under penalty of perjury, that I, and/or the persons for whom I am signing, am a United States citizen, Native American or national of the United States, or an immigrant with satisfactory immigration status.

I understand that signing the above Certification may result in information about recertifying members of my household being submitted to the United States Citizenship and Immigration Services (USCIS) for verification of immigration status, if applicable. The use or disclosure of the information above is restricted to persons and organizations directly connected with the verification of immigration status and the administration or enforcement of the provisions of the Temporary Assistance (TA), Food Stamp Benefits (FS), Medical Assistance (MA) Programs and the Medicare Savings Program (MSP).

*** A person who wishes to sign the Certification but cannot write may make an "X" on the line in front of a witness. The witness must sign below.**

I witnessed the marks made in lines: _____,_____,_____,_____,_____,_____ Signature of witness: _____ Date Signed: _____

NON-CUSTODIAL PARENT/CHILD SUPPORT/MEDICAL SUPPORT INFORMATION

DO NOT WRITE IN SHADED AREAS

If you are recertifying for Temporary Assistance, you must help us obtain child support/medical support for you and your children. If you are recertifying for Medical Assistance **only**, you may have to help us obtain medical support for yourself and your recertifying children. If you have questions, see the "How to Complete" instruction book (PUB-1313 Statewide). List the names of everyone under 21 whose parent is not in the household, and write down any information you currently have about that person's non-custodial parent. If **you** are under 21, write down the information about **your** non-custodial parent who is not in the household.

NAME OF PERSON UNDER 21	NON-CUSTODIAL PARENT'S NAME AND ADDRESS	NON-CUSTODIAL PARENT'S DATE OF BIRTH MONTH	DAY	YEAR	SOCIAL SECURITY NUMBER
A.					
B.					
C.	11				
D.					
E.					

Do you or does anyone who lives with you get money from child support payments? ☐ Yes ☐ No

If yes, list below:

WHO	AMOUNT RECEIVED	HOW OFTEN	FROM WHOM
	$		
	$		
	$		
	$		

Circle whichever arrangement applies:

Is there JOINT/SHARED/SPLIT custody? ☐ Yes ☐ No

If Yes, how was it determined? ☐ court order ☐ agreement of the parties

REQUESTED	DOCUMENTATION	IN FILE
	Paternity Acknowledgement	
	Child Support Order	
	Good Cause Form (LDSS-4279)	
	IV-D Attestation (LDSS-4281)	
	LRR Letter/Questionnaire	
	Other Support	
	Death Certificate	
	Divorce Decree	
	VA Benefits	
	Order of Filiation/Paternity	

NEEDED	REFERRALS	COMPLETED
	CTHP	
	CAP	
	CSS Application (LDSS-2521)	
	IV-D (LDSS-2860)	
	Paternity	

CONSIDER

- ✓ Health Insurance of Non-Custodial Parent/Absent Spouse
- ✓ Child Health Plus
- ✓ TASA
- ✓ Petition to Family Court
- ✓ SSI/SSA

ABSENT/DECEASED SPOUSE INFORMATION - If the husband or wife of anyone recertifying lives someplace else or is deceased, please indicate below.

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	DATE OF DEATH	SOCIAL SECURITY NUMBER
		12			

ADDRESS	CITY	COUNTY	STATE	ZIP CODE

ABSENT CHILD INFORMATION - If anyone recertifying has a child under 18 living someplace else, please indicate below.

NAME OF PERSON RECERTIFYING	NAME OF ABSENT CHILD	DATE OF BIRTH	ADDRESS *(Street, City, County, State and Zip Code)*	PATERNITY ESTABLISHED? Yes	No	DO YOU PAY CHILD SUPPORT? Yes	No
		13					

TEEN PARENT INFORMATION

Is there a teen parent under age 18 in the household? ☐ Yes ☐ No 14

Who _____

Does the teen parent's child live in the household? ☐ Yes ☐ No

Name of teen parent's child _____

TEEN PARENT:

LN NO. _____ Marital Status _____

High School Diploma? _____

LN NO. _____ Marital Status _____

High School Diploma? _____

TEEN PARENT CHILDREN

LN NO. _____ LN NO. _____

INCOME INFORMATION:

Indicate if you or anyone who lives with you receives money from:		YES	NO	WHO	AMOUNT/VALUE	WHO	AMOUNT/VALUE
Wages, Salary, Including Overtime, Commissions, Training Programs, Tips	1						
Self-Employment	2						
Unemployment Insurance Benefits	3						
Supplemental Security Income (SSI) Benefits	4						
Social Security Disability Benefits	5						
Social Security Dependent Benefits	6						
Social Security Survivor's Benefits	7						
Social Security Retirement Benefits	8						
Railroad Retirement Benefits	9						
Retirement Benefits (Pensions)	10						
Dividends/Interest from Stocks, Bonds, Savings, etc.	11						
Workers' Compensation	12						
NYS Disability Benefits	13						
Veteran's Pensions/Benefits/Aid and Attendance	14						
Public Assistance Grant	15						
GI Dependency Allotments	16						
Education Grants **or** Loans	17						
Contributions/Gifts (Received)	18						
Foster Care Payments (Received)	19						
Child Support Payments (Received)	20						
Alimony/Support (Received)	21						
Private Disability Insurance-Health/Accident Insurance Policy Income	22						
No Fault Insurance Benefits	23						
Union Benefits (Including Strike Benefits)	24						
Loans (Received)	25						
Income from a Trust (Including income you are currently entitled to receive, or were entitled to receive in the past, that has not been distributed.)	26						
Training Allotments	27						
Rental Income (Received)	28						
Boarders/Lodgers Income (Received)	29						
OTHER INCOME *(Please Specify)*							

STEP-PARENT/IMMIGRANT SPONSOR INFORMATION

Answer all Questions listed below

	YES	NO	WHO?
Does the step-parent of any children who live with you have any resources or receive any income of any kind?			
Is anyone in your household an immigrant who was sponsored for admission into the U.S.?			

NAME OF SPONSOR: TELEPHONE NO.:

ADDRESS:

DO NOT WRITE IN SHADED AREAS

INCOME

LN No.	SOURCE CODE	AMOUNT	PERIOD

CONSIDER

- ✓ Child Support Pass-Through ☐ Explained ☐ Budgeted
- ✓ FS Aged/Disabled Indicator
- ✓ Disability Review
- ✓ Change in Income from Last Budget
- ✓ Refugee Matched Grants

NEEDED	REFERRAL	COMPLETED
	UIB	

EMPLOYMENT INFORMATION

I am currently: ☐ employed ☐ self-employed ☐ unemployed

Gross Income $ _____ Current hours worked Monthly _____

Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly Day of the week paid _____

Employer's Name and Address: 1

_____ Phone No. _____

_____

Is anyone else who lives with you currently: ☐ employed ☐ self-employed

Who: _____

Gross Income $ _____ Current hours worked Monthly _____

Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly Day of the week paid _____ 2

Employer's Name and Address:

17

_____ Phone No. _____

_____

Is health insurance available through your employer? ☐ Yes ☐ No

Does anyone else have health insurance through their employer? ☐ Yes ☐ No

Who: _____ 3

Name of Insurance Company: _____

Does anyone have child or dependent care **expenses** due to **employment**? ☐ Yes ☐ No

Who: _____ 4

Does anyone have other employment-related expenses? ☐ Yes ☐ No

Who: _____ 5

If not employed, when was the last time you or anyone who lives with you worked?

Who: _____ When: _____

Where: _____ 6

Why did you (or they) stop working? _____

_____

Are you or is anyone who lives with you participating in a strike? ☐ Yes ☐ No

Who: _____ When: _____ 7

Are you or is anyone who lives with you a migrant or seasonal farm worker? ☐ Yes ☐ No

Who: _____ 8

What type of work would you like to do? (specify) _____

_____ 9

_____

Could you accept a job today? ☐ Yes ☐ No 10

If not, why? _____

DO NOT WRITE IN THE SHADED AREAS

REQUESTED	DOCUMENTATION	IN FILE
	CINTRAK/RFI/IRCS	
	1099	
	Employment Verification	
	Income Tax Return	
	Self-Employment Worksheet	
	Wage Stubs	
	Work Registration Form	
	Dependent/Child Care Form/Statement	
	Approval of Informal Child Care Provider	

NEEDED	REFERRALS	COMPLETED
	CAP	
	Disability	
	Employment	
	TPHI/COBRA	
	UIB	
	Worker's Compensation	
	Drug/Alcohol	
	Domestic Violence	

CONSIDER
✓ Earned Income Tax Credit (Flyer)
✓ Explaining Periodic Reporting Requirements
✓ Net Loss of Cash Income
✓ P.A.S.S. Income Amount and Sources
✓ Employment Sanctions
✓ Temporary Employment
✓ Disability Review
✓ Individual Development Account (IDA)
✓ Voluntary Quit

CHILD/DEPENDENT CARE EXPENSES

Who Pays	Amount	Name(s)	Age(s)	Care Provider
	$			
	$			
	$			
	$			
	$			
	$			
	$			
	$			

EDUCATION/TRAINING

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS RECERTIFYING FOR **OR GETTING ASSISTANCE:**

Has a High School diploma or G.E.D.? ☐ Yes ☐ No

Who _____ 1

Dates attended _____

Dates completed _____

Is or has been in any training program **in the last 12 months**? ☐ Yes ☐ No

Who _____

Where _____ 2

Program _____

Dates attended _____

Dates completed _____

Is 16 years of age or older and is attending school or college? ☐ Yes ☐ No

Who _____ 3

Where _____

Is getting a Training Allowance? ☐ Yes ☐ No 4

Who _____ Amt. $ _____

Is getting Educational Grants or Loans? ☐ Yes ☐ No 5

Who _____ Amt. $ _____

Is under 16 years of age and is attending school? ☐ Yes ☐ No

Who _____

School _____

Who _____

School _____

Who _____

School _____ 6

Who _____

School _____

Who _____

School _____

Who _____

School _____

DO NOT WRITE IN SHADED AREAS

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS-3708)	
	Educational Grant Worksheet	
	Child Care Statement	

NEEDED	REFERRALS	COMPLETED
	Supportive Services	

	YES	NO
Does anyone 18 through 49 who is attending college half-time or more meet the FS student eligibility requirement?		
Does anyone pay for child or dependent care to attend school or training?		
Is there a 16-19 year old parent who does not have a high school diploma or G.E.D., and who is not attending school?		
Is anyone in training?		
Are any other supportive services appropriate?		
Are there any training related expenses?		

RESOURCES INFORMATION

INDICATE IF YOU OR ANYONE WHO LIVES WITH YOU WHO IS RECERTIFYING:	YES	NO	WHO	IF YES, GIVE AMOUNT/VALUE	WHO	IF YES, GIVE AMOUNT/VALUE
Has cash on hand 1				$		$
Has a checking account(s) 2						
Has a savings account(s) or certificate of deposit(s) 3						
Has a credit union account(s) 4						
Has life insurance 5						
Has title or registration to a motor vehicle(s) or other vehicle(s) (Specify) Year _____ Make/Model _____ Year _____ Make/Model _____ 6						
Has stocks, bonds, certificates or mutual funds 7						
Has savings bonds 8						
Has an IRA, Keogh, 401-(k) or deferred compensation account(s) 9						
Has an irrevocable burial trust 10						
Has a burial fund 11						
Has a burial space 12						
Has own home 13						
Has real estate including income-producing and non-income-producing property 14						
Is eligible for an income tax refund 15						
Has an annuity 16						
Is named the beneficiary of a trust 17						
Expects to receive a trust fund, lawsuit settlement, inheritance or income from any other sources 18						
Has an "in trust" account(s) 19						
Has a safe deposit box 20						
Has resources other than those listed above 21						
Has anyone (including your spouse, even if not recertifying or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months? 22						
Has anyone (including your spouse, even if not recertifying or living with you) ever created a trust in the past or transferred any assets into a trust within the past 60 months? If yes, when? _____ 23						

19

VEHICLE INFORMATION

YR.	MAKE	MODEL	OWNER'S NAME	AMOUNT OWED	NADA VALUE	EXEMPT YES*	EXEMPT NO	LIEN HOLDER	ACCOUNT NO.
				$	$				
				$	$				

***IF EXEMPT, WHY?**

DO NOT WRITE IN SHADED AREAS

NEEDED	REFERRAL	COMPETED
	Legal	
	Resource	

LIFE INSURANCE

FACE AMOUNT	CASH VALUE

REQUESTED	DOCUMENTATION	IN FILE
	Resource Checklist	
	Market Value	
	DMV Clearance	
	Bank Statement	
	Assignment of Proceeds	
	Car/Vehicle Title	
	Car/Vehicle Registration (older models)	
	Bank Clearance	
	RFI/OCA	
	1099	

CONSIDER

- ✓ "In Trust" Accounts
- ✓ Children's Resources
- ✓ Lump Sum
- ✓ Boats, Campers, Snowmobiles
- ✓ Income Tax Refund
- ✓ Individual Development Account (IDA)
- ✓ Exempt Vehicles
- ✓ EIC
- ✓ Change in Resources from Last Budget

MEDICAL INFORMATION

DO NOT WRITE IN SHADED AREAS

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS RECERTIFYING:	YES	NO	IF YES, WHO
Has any medical bills or medically-related expenses 1			
Is on Medicaid with a spendown 2			
Has health or hospital/accident insurance (including insurance from employer) 3			
Has health insurance **available** through your employer 4			
Has Medicare (red, white, and blue card) 5			
Has a health attendant 6			
Is blind, sick or disabled 7			
Is a handicapped child 8			
Is in a hospital, nursing home or other medical institution 9			
Has paid or unpaid medical bills within 3 months preceding the month of this application 10			
Is or was drug or alcohol dependent 11			
Needs home care 12			
Is on SSI or has ever applied for SSI 13			
Is pregnant 14			
Receives treatment from a drug abuse or alcohol treatment program 16			
Has not been able to work for at least 12 months because of a disability or illness 17			
Has daily activity limited because of a disability or illness that has lasted or will last at least 12 months 18			
Has been in a car accident or work-related accident in the past two years 19			
Has any government agency (public program) besides Medical Assistance or Medicare paid any of your medical bills? 20			

20

POLICY NUMBER:

INSURANCE COMPANY NAME:

REQUESTED	DOCUMENTATION	IN FILE
	Pregnancy Statement	
	Med/Psych Statement	
	Drug/Alcohol Screening (LDSS-4571)	
	Drug/Alcohol Statement	
	Paid or Unpaid Medical Bills	
	SSI Application Verification **TA ONLY**	

IF PREGNANT, PLEASE GIVE DUE DATE: _____ 15

CONSIDER

- ✓ AD/SSI Related
- ✓ FS Aged/Disabled Indicator
- ✓ FS Medical Deduction
- ✓ TPHI Reimbursement
- ✓ Buy-In Eligibility
- ✓ Kreiger (LDSS-3664)
- ✓ Domestic Violence
- ✓ SSI Referral
- ✓ Earned Income Credit
- ✓ Change in Resources

NEEDED	REFERRALS	COMPLETED
	SSI (D-CAP)	
	Disability Interview (LDSS-1151)	
	Medical Report (LDSS-486, 486t)	
	Disability Report	
	AD	
	TPHI	
	VESID	
	CTHP	
	PCAP	
	Family Planning	
	TASA	
	SSA (RSDI)	
	Veteran's Benefits	
	Veteran's Counseling	
	Child Health Plus	
	COBRA Eligibility	
	Nurse's Aide Service	
	Home Care	

HEALTH PLAN SELECTION

Persons eligible for Family Health Plus must join a health plan to receive their health services. Some people enrolled in Medicaid may be required to join a health plan now and others may be required to join one soon. Use this section to choose a health plan. If you do not know what health plans are available, ask your worker.

NOTE: If you are in a county that does not require Medicaid recipients to join a health plan, you will still be enrolled in the health plan(s) you choose, unless you check this box. ☐

Check (✓) Program	Name of Plan you are enrolling in (Adults age 19 to 64 must pick a FHPlus Plan)	Last Name	First Name	Date Of Birth mm/dd/yy	SEX M/F	ID# (from Medicaid Card if you have one)	Social Security # (optional if pregnant)	Primary Care Provider (PCP) or Health Center (check box if current provider)	Name and ID# of OB/GYN (check box if current provider)
☐ MA ☐ FHPLUS								☐	☐
☐ MA ☐ FHPLUS								☐	☐
☐ MA ☐ FHPLUS								☐	☐
☐ MA ☐ FHPLUS								☐	☐

SHELTER

WHAT IS YOUR LANDLORD'S NAME?

_____

WHAT IS YOUR LANDLORD'S ADDRESS?

_____

_____

_____

WHAT IS YOUR LANDLORD'S PHONE NUMBER?

( ) _____

	YES	NO	IF YES, GIVE AMOUNT
Do **you (or anyone who lives with you)** have a rent, mortgage or other shelter expense?			$

Do **you (or anyone who lives with you)** have the following expenses separate from your rent or shelter expense?	YES	NO
• Heat 1		
• Electricity (for lights, cooking, hot water) 2		
• Gas (for cooking, hot water) 3		
• Other utilities (water, etc.) 4		
• Air conditioning (monthly fee, or pay own electric) 5		
• Utility installation fees 6		
Does any person, group or organization outside the household pay any of the household expenses? 7		
Do you live in public housing?		
Do you live in Section 8 or other subsidized housing?		
Do you live in a drug/alcohol rehab. facility?		
Do you live in a domestic violence shelter?		

SHELTER COSTS	MONTHLY ACTUAL COST
A. Room and Board	
B. Rent	
C. Trailer Lot Rent	
D. Mortgage Payment	
1. Principal	
2. Interest	
3. Property Tax (Including School Tax)	
4. Homeowner's Insurance on Structure (Incl. Fire Insurance)	
5. Taxes Included in Mortgage (Escrow Payment)	
6. Assessments (Sewer, etc.)	
D. Total Mortgage Payment (Line 1-6)	
E. Utility Installation Fees	
TOTAL *(Lines A - E)*	

DO NOT WRITE IN SHADED AREAS

REQUESTED	DOCUMENTATION	IN FILE
	Landlord Statement	
	Rent Receipt	
	Tenant of Record	
	Customer of Record	
	Voluntary Restrict	
	Mandatory Restrict	
	Subsidized Housing	
	Mortgage/Title Search	
	Section 8 Lease or Statement from Section 8 Office	
	Property Lien	
	Shelter/Utility Repayment Agreement	

CONSIDER

- ✓ Utility and/or Fuel Restrict
- ✓ Utility Guarantee
- ✓ HEAP
- ✓ Subsidized Housing May Show Total Rent, NOT Client Amount
- ✓ Foster Care Related Additional Allowances
- ✓ FS Household Comp. Rules
- ✓ FS Aged/Disabled Indicator
- ✓ Real Property Tax Credit
- ✓ Lifeline
- ✓ AIDS/HIV Emergency Shelter Allowance
- ✓ Property Lien
- ✓ If Shelter Expenses/Living Quarters are Shared by More Than One Household

MONTHLY EXPENSES	MONTHLY ACTUAL COST	NAME OF DEALER	ACCOUNT NUMBER	IN WHOSE NAME IS THE BILL? (CUSTOMER OF RECORD)	WHO IS THE TENANT OF RECORD?
A. Heat*					
B. Electricity (for cooking, lights, hot water)					
C. Gas (for cooking, hot water)					
D. Liquid Propane Gas					
E. Other Utilities (Water, etc.)					
F. Air Conditioning					
G. Utility Installation Fees					
H. Sewer					
I. Garbage					
J. Trash					
K. Other Expenses					

***Check Primary Heat Type:**

☐ Natural Gas ☐ Oil ☐ PSC Electric ☐ Coal ☐ Other _____

☐ Kerosene ☐ Propane ☐ Municipal Electric ☐ Wood

ADDITIONAL INFORMATION

OTHER EXPENSES

INDICATE IF **YOU OR ANYONE WHO LIVES WITH YOU** WHO IS RECERTIFYING:	YES	NO	IF YES, GIVE AMOUNT
Pays child support 1			$
Pays alimony 2			$
Pays child care 3			$
Pays dependent care 4			$
Pays tuition and fees 5			$
Has additional expenses Specify _____ 6			$

Do you or anyone who lives with you who is recertifying owe at least four months' court-ordered support for a child under age 18? 7	☐ YES	☐ NO

OTHER INFORMATION

Do you buy or plan to buy meals from a home delivery or communal dining service? 8	☐ YES	☐ NO
Are you able to prepare meals at home? 9	☐ YES	☐ NO
Have you or anyone in your household ever been in the U.S. military? Who? _____ 10	☐ YES	☐ NO
Has your spouse ever been in the U.S. military? 11	☐ YES	☐ NO
Is anyone in your household a dependent of someone who is or was in the U.S. military? Who? _____ 12	☐ YES	☐ NO

NEEDED	REFERRALS	COMPLETED	CONSIDER
	Services		✓ FS Dependent Care Deductions
	UIB		✓ District of Fiscal Responsibility (SSL 62.5)

DO NOT WRITE IN SHADED AREAS

HOW OFTEN PAID	LEGALLY OBLIGATED		CHILD IN FS HH	
	Yes	No	Yes	No

VETERAN STATUS	VETERAN CODE

OTHER INFORMATION (cont.)	YES	NO	WHO
Have you or anyone who lives with you who is recertifying moved into **this** county from another **New York State** county within the past two months?			
Have you or anyone who lives with you ever been found guilty of and/or been disqualified for Temporary Assistance and/or Food Stamp Benefits because of fraud/intentional program violation?			
Have you or anyone who lives with you received benefits for which they were not entitled, which have not been fully repaid to this or another agency?			
Have you or any member of your household been convicted of making a fraudulent statement or representation of residence in order to receive Temporary Assistance in two or more states?			
Are you or any member of your household fleeing prosecution, confinement or conviction for a felony?			
Are you or any member of your household violating probation or parole?			

PROPERTY TRANSFER STATUS

I have ☐ **I have not** ☐ sold, transferred or given away any of my property to anyone to get Temporary Assistance or Food Stamp Benefits.

REQUESTED	DOCUMENTATION	IN FILE
	School Attendance Verification (LDSS-3708)	
	Child/Dependent Care Statement	
	Recoupments	
	Outstanding Overpayment	
	Pending Disqualification	

Based on the information contained in this recertification, make sure you reconsider the category. For PA, especially, consider the following:

- Eligible Child Status
- Essential Persons Status
- FA Extensions

Category is _____

Documented by _____

IF TOTAL EXPENSES (INCLUDING EXPENSES NOT USED IN THE BUDGET DETERMINATION) EXCEED INCOME (INCLUDING TA GRANT), EXPLORE HOW THE HOUSEHOLD IS MEETING ITS OBLIGATIONS.

Actual Expenses $

- Actual Income $

= Difference $

	YES	NO
Does Client Receive Contribution Towards Difference?	☐	☐

If Yes, From Whom? _____

CONSIDER

- ✓ Actual Expenses
- ✓ Actual Shelter
- ✓ Actual Fuel/Utility Costs
- ✓ Telephone Expenses
- ✓ Car Expenses
- ✓ Furniture/Appliance Rental
- ✓ Cable TV
- ✓ Private School Tuition
- ✓ Out-of-Pocket Medical Expenses

I REQUEST THAT MY CASE BE CLOSED FOR:

☐ Temporary Assistance ☐ Food Stamp Benefits

☐ Medical Assistance ☐ Medicare Savings Program

I understand that I may reapply at any time.

Give reason: _____

Signature **x**_____ Date _____

NOTES/COMMENTS

READ THE IMPORTANT INFORMATION BELOW.

NOTICES

PRIVACY ACT STATEMENT - COLLECTION AND USE OF SOCIAL SECURITY NUMBERS (SSNs) - The collection of SSNs is authorized for each household member with respect to Food Stamp Benefits pursuant to the Food Stamp Act of 1977 (as amended, 7 US Code 2011-2036).

With respect to all other programs for which this recertification form requires a SSN, the collection of SSNs is also mandatory and is authorized under one or more of the following sections of law: 205(c) of the Social Security Act (42 U.S. Code 405), Section 1137 of the Social Security Act (42 U.S. Code 1320b-7) and Section 7(a)(2) of the Privacy Act of 1974. See the "How To Complete" instruction book Sections 6 and 24 or talk to your worker.

The information we collect will be used to determine whether your household is eligible or continues to be eligible for assistance or benefits. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

This information may be disclosed to other State and Federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

The information will be used to check identity, to verify earned and unearned income, to determine if absent parents can receive health insurance coverage for applicants or recipients, to determine if applicants or recipients can obtain child or spousal support and to determine if applicants or recipients can receive money or other help.

Information collected with respect to applicants for and recipients of Family Assistance and Safety Net Assistance, including SSNs, may be used to assist in the formation of jury pools.

If a FS claim arises against your household, the information on this recertification, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including the SSN of each household member, is voluntary for Food Stamp Benefits. However, anyone applying who fails to give a SSN will be denied FS. SSNs of ineligible members will also be used and disclosed in the manner above.

REIMBURSEMENT OF MEDICAL EXPENSES

MEDICAID - You have a right as part of your Medical Assistance application, or within two years from the date of your application, to request reimbursement of expenses you paid for covered medical care, services and supplies received during the three month period prior to the month of your application. After the date of your application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid-enrolled providers.

FAMILY HEALTH PLUS - If you are determined eligible for Family Health Plus, your enrollment will be effective no later than 90 days from the date of submission of your completed application. If there is an error or delay in enrollment, reimbursement may be available for expenses you pay as a result of the error or delay. Unpaid expenses can be paid only if the provider is a Medicaid enrolled provider.

SUPPORT - Applying for or receiving Family Assistance (FA), Safety Net Assistance (SNA) or foster care services operates as an assignment to the State and the social services district of any rights to support from any other person that the applicant or recipient may have in his or her own right or on behalf of any other family member for whom the applicant or recipient is applying or receiving assistance (Social Services Law, 158 and 348). Other sections of this recertification contain additional assignments.

NON-DISCRIMINATION NOTICE - In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

FOOD STAMP BENEFITS AUTHORIZED REPRESENTATIVE - You can authorize someone who knows your household circumstances to **apply** for Food Stamp Benefits (FS) for you. You can also authorize someone outside your household to get FS for you or to use them to buy food for you. If you would like to authorize someone, print the person's name, address and phone number directly below.

When an Authorized Representative is applying on behalf of a Food Stamp Benefits Household that does not reside in an institution, **both** the Authorized Representative and the Food Stamp Benefits Head of Household must sign and date the signature sections at the bottom of page 16.

NAME, ADDRESS AND PHONE NUMBER OF AUTHORIZED REPRESENTATIVE *(PLEASE PRINT)*

PENALTIES - Your recertification may be investigated. By signing this agreement you are consenting to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Temporary Assistance, Medical Assistance, Food Stamp Benefits, Services or Child Care Assistance (Assistance, Benefits or Services) or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your recertification or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Assistance, Benefits or Services, or if you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive Assistance, Benefits or Services; and such Assistance, Benefits or Services must be used for the other person and not for yourself. Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within 36 months (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and has submitted an application for Medical Assistance, **may** render the individual ineligible for nursing facility services or home and community based waivered services for a period of time. It is unlawful to obtain Assistance, Benefits or Services by concealing information or providing false information.

READ THE IMPORTANT INFORMATION BELOW.

NOTICES (cont.)

FOOD STAMP BENEFITS (FS) PENALTY WARNING

Any information you provide in connection with your application for Food Stamp Benefits will be subject to verification by Federal, State and local officials. If any information is incorrect, you may be denied FS. You may be subject to criminal prosecution for knowingly providing incorrect information.

You will **never** be able to get FS again if you are:

- Found guilty in a court of law for the second time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for FS; **or**
- Found guilty in a court of law of selling or getting firearms, ammunition or explosives in exchange for FS; **or**
- Found guilty in a court of law of trafficking in FS worth $500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of FS, authorization cards or access devices; **or**
- Found guilty of committing a third Intentional Program Violation (IPV).

You will not be able to get FS for two years if you are found guilty in a court of law for the first time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for FS.

If you have committed your:

- First IPV, you will not be able to get FS for one year.
- Second IPV, you will not be able to get FS for two years.

A court could also bar you from receiving Food Stamp Benefits for an additional 18 months.

If you make a false statement about who you are or where you live in order to get multiple FS, you will not be able to get FS for ten years (or **permanently** if this is the third IPV).

You may be found guilty of an Intentional Program Violation if you:

- Make a false or misleading statement, or misrepresent, conceal or withhold facts; **or**
- Commit any act that constitutes a violation of Federal or State law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of coupons, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system.

You could also be fined up to $250,000, sent to jail for up to 20 years, or both.

ASSIGNMENTS. AUTHORIZATIONS & CONSENTS

ASSIGNMENT OF INSURANCE AND OTHER BENEFITS - For Temporary Assistance and Medical Assistance, I agree to file any claims for health or accident insurance benefits and to pursue any personal injury claims or any other resources to which I may be entitled, and do hereby assign any such resources to the social services official to whom this recertification is made. In addition, I will assist in making any assigned benefits available to the social services official to whom this recertification is made.

TEMPORARY ASSISTANCE (TA) RECOVERIES - TA you receive for yourself and for persons for whom you are legally responsible to support is recoverable from property or money you possess or may acquire. You may be required, as a condition of receiving TA, to execute a deed or mortgage of real property you own. Your tax refunds and portions of lottery winnings may be taken to repay your debt for TA.

MEDICAL ASSISTANCE (MA) RECOVERIES - Upon receipt of MA, 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. MA paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. MA may also recover the cost of services and premiums incorrectly paid.

CHILD/TEEN HEALTH PROGRAM - I understand that if my child is on Child Health Plus A (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 Department of Social Services.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES - Your household must report child care and utility expenses in order to get a FS deduction for these expenses. Your household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a FS deduction for these expenses.

Failure to report/verify the above expenses will be seen as a statement by your household that you do not want to receive a deduction for those unreported/unverified expenses. A deduction for these expenses may make you eligible for FS or may increase your FS benefits. You may report/verify these expenses at any time in the future. This deduction would then be applied to the calculation of FS benefits in future months in accordance with the rules for change reporting.

DIRECT PAYMENT - I authorize payments owed to me or members of my household for health or accident insurance benefits to be made directly to the appropriate social services official for medical and other health services furnished while we are eligible for Medical Assistance.

MEDICARE - I authorize payments under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medical Assistance.

CHANGES – I agree to inform the agency **promptly** of any changes, to the best of my knowledge and belief, including, but not limited to, any change in my needs, residency/address, living arrangements, household size, income, employment, property/resources, dependent care costs, health insurance, immigration/citizenship status or pregnancy.

If I am applying for child care assistance, I agree to inform the agency **immediately** of any change in family income, who lives in my house, employment, child care arrangements or other changes which may affect my continued eligibility or amount of my benefit.

CONSENT FOR INVESTIGATION - I agree to any investigation to verify or confirm the information I have given in connection with my request for TA, MA, FS, Services or Child Care Assistance. If additional information is requested, I will provide it. I will also cooperate fully with State and Federal personnel in a Temporary Assistance and/or Food Stamp Quality Control Review.

TURN TO THE BACK PAGE (PAGE 16) AND READ AND SIGN AT THE BOTTOM OF PAGE 16 ➜

READ THE IMPORTANT INFORMATION BELOW AND SIGN AT THE BOTTOM.

ASSIGNMENTS, AUTHORIZATIONS & CONSENTS (cont.)

STANDARD UTILITY ALLOWANCE (SUA) - I understand that Temporary Assistance (TA) and Food Stamp Benefits (FS) recipients are categorically income eligible for the Home Energy Assistance Programs (HEAP). If I am not included in the annual automatic HEAP payment process for certain TA and FS recipients, I intend to apply for a HEAP benefit within the next 12 months. If I decide not to apply for HEAP within the next 12 months, I will let my worker know. I understand that FS recipients are eligible for a telephone allowance if they pay for a home phone, cell phone, phone calling card or coin-operated pay phone. If I do not have to pay for phone calls, I will let my worker know.

ASSIGNMENT OF SUPPORT RIGHTS - I assign to the State and social services district any rights I have to support from persons having legal responsibility for my support and any rights I have to support on behalf of any family member.

RELEASE OF EDUCATIONAL RECORDS - I give permission to the State Department of Health and local department of social services to:

- Obtain any information regarding the educational records of myself and/or my minor child(ren), herein named, including information necessary for claiming MA reimbursement for health-related educational services.
- Provide the appropriate federal government agency access to this information for the sole purpose of audit.

RELEASE OF INFORMATION FOR THE 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 Medical Assistance eligibility information with my county or municipal Early Intervention Program for the purpose of billing Medical Assistance.

RELEASE OF MEDICAL INFORMATION - I consent to the release of any medical information about me and any members of my family for whom I can give consent: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus and Family Health Plus 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 may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

LIFELINE - For applicants/recipients of Temporary Assistance and/or Food Stamp Benefits: The Office of Temporary and Disability Assistance may or may not release your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate.

If you *do not* want this information released, check this box ☐ .

You may contact your telephone service provider directly for enrollment in the discounted rate Lifeline Service.

Medicaid-**only** applicants/recipients must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service.

AUTHORIZATION FOR REIMBURSEMENT OF PUBLIC ASSISTANCE BENEFITS FROM SSI RETROACTIVE PAYMENT - I authorize the Commissioner of the Social Security Administration (SSA) to send to the local social services district the amount that is due to me at the time of my first payment of (1) retroactive Supplemental Security Income (SSI) benefits that I may receive upon an application for SSI or (2) retroactive SSI benefits I may receive if my SSI benefits are terminated or suspended and are later reinstated.

I understand that the local social services district may take from my retroactive SSI payment the amount of Public Assistance (except assistance paid wholly or partly with federal funds) that it paid to me during the period that begins (1) with the first day I became eligible for payment of SSI benefits or (2) the first day to which SSI benefits were reinstated after a period of suspension or termination and ends with the month that SSI payments actually began (or the following month if the local social services district cannot stop delivery of my last public assistance payment during the month that SSI payments resume).

After taking this money from my SSI check(s), the local social services district will pay me the balance, if there is any, no later than 10 working days from the date it receives my SSI payment. I also understand that if the district takes more money than I believe was paid to me as Public Assistance, I will be given an opportunity for a hearing.

I understand that:

- the SSA may treat the date that I submit this signed authorization to the local social services district as the date I first become eligible for SSI if I submit an application for initial SSI benefits within the next 60 days.
- this authorization will apply to any SSI application or appeal which is presently pending before the SSA with respect to me and to any SSI application I make or appeal I request with respect to the period ending one year after I sign this agreement. It will not have any effect on cases that have been completely decided or if the SSA has already made an initial payment of SSI either on my application or after a period of suspension or termination or if the State and I have mutually agreed to terminate the authorization.

This authorization will terminate one (1) year after it is received by the local social services district and will not have any effect upon new SSI applications made after that date.

I have read and understand the notices above. I understand and agree to the assignments, authorizations and consents above. I swear and/or affirm under the penalties of perjury that the information I have given or will give to the local social services district is correct.

APPLICANT SIGNATURE	DATE SIGNED	HUSBAND/WIFE OR PROTECTIVE REPRESENTATIVE SIGNATURE	DATE SIGNED
X		X	
AUTHORIZED REPRESENTATIVE SIGNATURE	**DATE SIGNED**		
X			

NYS Agency-Based Voter Registration Form

ESTE FORMULARIO ESTÁ DISPONIBLE EN ESPAÑOL

本表格有中文文本

"If you are not registered to vote where you live now, would you like to apply to register here today?"

☐ YES **(If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)**

☐ NO because I choose not to register OR

☐ I am already registered at my current address OR

☐ I asked for and received a mail registration form.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____ ___/___/___
(Signature) (Date)

_____
(Please Print Name)

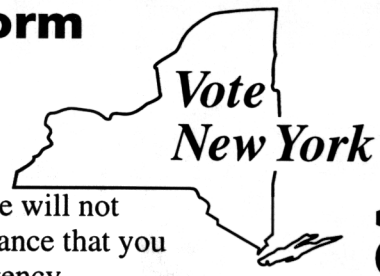
Qualifications for Registration

You Can Use This Form To:

- **register to vote in New York State**
- **change your name and/or address, if there is a change since you last voted**
- **enroll in a political party or change your enrollment**

To Register You Must:

- **be a U.S. citizen**
- **be 18 years old by December 31 of the year in which you file this form (note: you must be 18 years old by the date of the general, primary, or other election in which you want to vote.)**
- **be a resident of the County, or of the City of New York at least 30 days before an election.**
- **not be in jail or on parole for a felony conviction**
- **not claim the right to vote elsewhere**



IMPORTANT!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with *New York State Board of Elections, 40 Steuben Street, Albany, New York 12207-2109.*
Tele: 1-800-469-6872, TTY 1-800-533-8683; or visit our web site - www.elections.state.ny.us

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

VOTER REGISTRATION FORM

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (10/03)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1 Are you a U.S. citizen? Yes ☐ No ☐
If you answered NO, do not complete this form.

2 I will be 18 years old on or before election day: Yes ☐ No ☐
If you answered NO, do not complete this form, unless you will be 18 by the end of the year.

For Board use only!

3 Last Name | First Name | Middle Initial | Suffix

4 Address Where You Live (do not give P.O. address) | Apt. No. | City/Town/Village | Zip Code | County

5 Address Where You Get Your Mail (if different from above) | P.O. box, star rte., etc. | Post Office | Zip Code

6 Date of Birth

7 Sex (circle) M F

8 Home Tel. Number (optional)

9 ID Number - Check the applicable box and provide your number
☐ New York Driver's License Number ☐ Last four digits of your Social Security number
➜
☐ I do not have a New York driver's license number or a Social Security number.

10 The last year you voted | Your Address was (give house number, street, and city)
In county/state | Under the name (if different from your name now)

11 **Choose a Party** — Check one box only
☐ REPUBLICAN PARTY
☐ DEMOCRATIC PARTY
☐ INDEPENDENCE PARTY
☐ CONSERVATIVE PARTY
☐ WORKING FAMILIES PARTY
Please note: In order to vote in a **primary election,** you must be enrolled in one of these parties.
☐ OTHER (write in)_____
☐ I DO NOT WISH TO ENROLL IN A PARTY

12 **AFFIDAVIT**: I swear or affirm that
- I am a citizen of the United States.
- I will have lived in the county, city, or village for at least 30 days before the election.
- I meet all requirements to register to vote in New York State.
- This is my signature or mark on the line below.
- The above information is true. I understand that if it is not true I can be convicted and fined up to $5,000 and/or jailed for up to four years.

↓Signature or mark ↓

X _____ Date

Please do not write in this space

TO COMPLETE THIS FORM:

***Box 1*:** Must be completed. If you answer NO, do not complete this form.

Box 2: Must be completed, however if you check NO, do not complete this form UNLESS you are a New York resident who will be 18 by the end of this year.

Box 4: Give your home address.

Box 5: Give your mailing address if it is different from your home address (post office box no., star route or rural route no., etc.)

Box 8: The completion of this box is optional.

Box 9: Must be completed. If you have a current New York driver's license, you must provide that number. If you do not have a current New York driver's license, you must provide the last four digits of your social security number.

Box 10: If you have never voted before, write "None." If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same."

Box 11: In order to vote in a party primary, you must be enrolled in one of New York's 5 constituted parties. Check one box only.

Box 12: This application must be signed and dated in ink.

NEW YORK STATE
HOW TO COMPLETE THE
TEMPORARY ASSISTANCE (TA) – MEDICAL ASSISTANCE (MA) – MEDICARE SAVINGS PROGRAM (MSP) – FOOD STAMP BENEFITS (FS) RECERTIFICATION FORM

Whenever you see "Temporary Assistance" or "TA" on the recertification form, it means "Family Assistance" and "Safety Net Assistance". We call both of these Public Assistance Programs "Temporary Assistance". Social Services programs were created to give temporary help to those in need. Certain programs now have time limits on how long you can get help. It is important for you to achieve self-sufficiency as soon as you can. The local Department of Social Services is here to help you with your goal of self-sufficiency. In order to help you, we must know who you are and what you need. This is why you have been asked to fill out this recertification form. The things this recertification form will tell us about you are:

- **Who you are**
- **Where you live**
- **How you have been living**
- **How we can help you**

The directions and recertification form are numbered by Section to help you. You may write over these numbers when appropriate.

- PLEASE PRINT CLEARLY
- DO NOT WRITE IN THE SHADED AREAS
- BE SURE TO COMPLETE EACH SECTION THAT APPLIES TO YOU
- IF YOU ARE RECERTIFYING AS SOMEONE'S REPRESENTATIVE, PLEASE PRINT INFORMATION ABOUT THAT PERSON, NOT YOURSELF.
- IF YOU HAVE ANY DISABILITIES WHICH PREVENT YOU FROM COMPLETING THIS RECERTIFICATION FORM AND/OR WAITING TO BE INTERVIEWED, PLEASE NOTIFY THE RECEPTIONIST. THE AGENCY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATION TO ADDRESS YOUR NEEDS.

DISCONTINUE: IF YOU WANT TO STOP GETTING ASSISTANCE, TALK TO YOUR ELIGIBILITY EXAMINER.

In addition to the LDSS-3174: "Recertification Form", make sure you have been given copies of:

- **LDSS-4148A**: "What You Should Know About Your Rights and Responsibilities"
- **LDSS-4148B**: "What You Should Know About Social Services Programs"
- **LDSS-4148C**: "What You Should Know If You Have An Emergency"

PAGE 1 OF THE RECERTIFICATION FORM

1 **PROGRAMS:** Check (✓) the box for EACH program that you or any household member wants to recertify for. Because of welfare reform, a recertification form for Temporary Assistance is no longer automatically a recertification form for Medical Assistance. **If you want to recertify for both Temporary Assistance and Medical Assistance, check (✓) the Temporary Assistance and Medical Assistance box. If you want to recertify for the Medicare Savings Program, check (✓) the Medicare Savings Program box. Medical Assistance includes the Medicaid, Family Health Plus, Child Health Plus A, Medicaid Buy-In for Working People with Disabilities and Family Planning Benefit programs. If you want to recertify for any of these programs, check (✓) the Medical Assistance box.**

If you are recertifying for Temporary Assistance and Food Stamp Benefits, and/or Medical Assistance, usually you will be required to have only a single interview for all programs. If you are recertifying for Medical Assistance only, you do not have to have an interview.

2 **DO YOU WANT TO RECEIVE NOTICES IN:** Check (✓) the "Spanish and English" **or** "English Only" box.

WHAT IS YOUR PRIMARY LANGUAGE: Check (✓) the English or Spanish or Other box and enter your primary language.

RECIPIENT INFORMATION

NAME: PRINT your legal name including your first name, middle initial, and last name.

MARITAL STATUS: PRINT whether you are **now** single, married, widowed, legally separated or divorced.

PHONE NO: PRINT your home phone number. Include your area code.

RESIDENCE ADDRESS: PRINT the house number, street, avenue, road, etc., where you now live.

3 **Apt No:** PRINT the number of your apartment.

City: PRINT the city you live in.

County: PRINT the county you live in.

State: PRINT the state you live in.

Zip Code: PRINT the zip code for your address.

CARE OF NAME: If you receive your mail in care of someone else, PRINT that person's name.

MAILING ADDRESS: If you get your mail somewhere other than where you live, PRINT that address in this space.

AGENCY HELPING RECIPIENT: If an agency is helping you recertify, PRINT the name of the agency, the person helping you from the agency and the person's telephone number.

HOW LONG HAVE YOU LIVED AT PRESENT ADDRESS: PRINT the number of years and/or months that you have lived where you are now living.

RECIPIENT INFORMATION (continued)

ANOTHER PHONE: If you can be reached at someone else's phone, PRINT that person's name and telephone number. If you are working, PRINT your employer's name and telephone number.

DIRECTIONS TO HOME: PRINT directions on how to find your home. Use commonly known landmarks.

FORMER ADDRESS: PRINT the address where you lived before you moved to your present address.

4 **FOOD STAMP BENEFITS RECIPIENTS:** You have the right to turn in your Food Stamp Benefits recertification form during office hours on the same day you get the form. It must be accepted if it has at least your name, address (if you have one) and signature. To figure out if you can get Food Stamp Benefits, however, you will have to fill out the whole form.

5 **DO ANY OF THESE APPLY TO YOU?** Check (✓) EACH item that applies to you.

PAGES 2 AND 3 OF THE RECERTIFICATION FORM

HOUSEHOLD MEMBERS INFORMATION

LIST THE NAMES OF EVERYONE WHO LIVES WITH YOU, EVEN IF THEY ARE NOT RECERTIFYING WITH YOU. PRINT your full name first. Then PRINT the names of the other people who live with you:

- Check (✓) the type(s) of Assistance each person is recertifying for: Temporary Assistance (TA), Food Stamp Benefits (FS), Medical Assistance (MA), and/or Medicare Savings Program (MSP).

  NOTE: If you are recertifying for the MSP, complete all sections required for MA.

- PRINT the date of birth and sex for **each** person who is recertifying.
- For each person who is recertifying, PRINT their relationship to you (For example: wife, son, foster child, friend, roomer, boarder, etc.).
- PRINT each person's Social Security Number **unless that person is:**
  - Not recertifying for assistance of any kind; or
  - A pregnant woman who is recertifying **only** for Medical Assistance.

6

- Highest School Grade Completed: Enter the highest school grade (1-12) completed for each person recertifying for assistance. If more than 12 years, enter 13. If no formal schooling, enter 0. If you are recertifying **only** for Medical Assistance, you do not have to answer this question.
- Purchasing or Preparing Meals: It is important to check (✓) YES or NO to the Question "Does this person (including your minor children) buy food or prepare meals with you?" for every person who lives with you. Sometimes, people who buy food and prepare meals separately may get more Food Stamp Benefits.

HOUSEHOLD MEMBERS INFORMATION (continued)

- Race/Ethnic Affiliation: You must fill out this section for each person recertifying for assistance. Enter **Yes** or **No** if your ethnicity is Hispanic or Latino also enter the letter that best tells your racial background. This information is required by the Federal government. If you do not fill out this section, an interviewer in the agency must fill it out based on observation.

If you are recertifying for Medical Assistance **only,** you may fill out this section if you want to. If you do not fill out this section, an interviewer in the agency may fill it out based on observation.

PAGE 2 OF THE RECERTIFICATION FORM

7 **OTHER NAMES INFORMATION**

PRINT any maiden names, names from a previous marriage, or other names which any person listed above has used or now uses.

CHANGE IN HOUSEHOLD MEMBER

8 Complete this section if anyone has moved **into** or **out of** your household during the past year.

PAGE 4 OF THE RECERTIFICATION FORM

CITIZENSHIP/IMMIGRATION STATUS INFORMATION

Complete this section if you are recertifying for **Medical Assistance, Temporary Assistance or Food Stamp Benefits.**

NOTE: You **DO NOT** have to complete this certification if you are recertifying for **Medical Assistance only** and

- You are pregnant, or
- You are *not* a **U. S. citizen, Native American or national of the United States** *or* **an immigrant with satisfactory immigration status. "Satisfactory immigration status" is an immigration status which does not make the individual ineligible for benefits under the applicable program.** If you have any questions about your immigration status, please see LDSS-4148B: "What You Should Know About Social Services Programs" or talk to your worker.

9

NOTE: You **DO** have to fill out this section if you are:

- Recertifying for Medical Assistance **only,** but you do not have to include people who do not want Medical Assistance.

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS INFORMATION

If you are recertifying for **Medical Assistance, Temporary Assistance or Food Stamp Benefits,** you **must complete and sign** this written certification of citizenship or satisfactory immigration status.

NOTE: The term "satisfactory immigration status" means an immigration status which does not make the individual ineligible for benefits under the applicable program. If you have any questions about your immigration status, please see LDSS-4148B: "What You Should Know About Social Services Programs" or talk to your worker.

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NOTE: You **DO NOT** have to sign this certification if you are recertifying for **Medical Assistance only** and:

- You are pregnant, or
- You are *not* a **U. S. citizen, Native American or national of the United States** *or* **an immigrant with satisfactory immigration status.**

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS INFORMATION (continued)

NOTE: You **MUST** sign this certification only if you are a **U.S. citizen, Native American** or **national of the United States,** or **an immigrant with satisfactory immigration status,** and you are recertifying for:

- Temporary Assistance (where there are children in the household or a member of the household is pregnant); or
- Food Stamp Benefits; or
- Medical Assistance (except if the recipient is pregnant); or
- Medicare Savings Program.

A signature and date of signing must be given for all persons recertifying for these benefits, except as noted above.

- An adult household member or authorized representative may sign for all recertifying household members.
- If a recertifying household member is under 18 (or is 18 or older but is unable to sign their own name due to a medical impairment or disability), a household member who is 18 or older must sign for them.

NOTE: When signing for another individual, sign *your* own name. **For example**, Mary Doe, when signing for infant Johnny Doe, must sign Mary Doe.

A *parent* without satisfactory immigration status may sign for his/her *child* who has satisfactory immigration status. **For example,** a mother who does not have satisfactory immigration status may still sign the certification for her children who are U. S. citizens.

NOTICE

You should not sign this declaration for yourself or for another person who is not a U. S. citizen, Native American or national of the United States or an immigrant with satisfactory immigration status. Non-citizens without satisfactory immigration status are not eligible for any Temporary Assistance, Food Stamp Benefits or Medical Assistance benefits (except Medical Assistance for a pregnant person or Medical Assistance coverage ONLY for treatment of an emergency medical condition). Such persons may also be ineligible for certain Services.

We may confirm the immigration status of any or all household members recertifying for Temporary Assistance, Medical Assistance benefits or Food Stamp Benefits (or Services) by submitting the information you give us to the United States Citizenship and Immigration Services (USCIS). Information received from the USCIS may affect your household's eligibility and level of benefits.

PAGE 5 OF THE RECERTIFICATION FORM

NON-CUSTODIAL PARENT/CHILD SUPPORT/MEDICAL SUPPORT INFORMATION

If you are recertifying for Temporary Assistance, Medical Assistance or the Medicare Savings Program, fill out this Section if any of the following apply:

11

1. You or anyone who lives with you is pregnant and the father of the unborn child lives someplace else.
2. You are recertifying for any person under 21 and this person's parent(s) lives outside of the household.
3. You are under 21 and your parent(s) do not live with you.

NOTE: You do not need to fill out this section if you are recertifying only for Medical Assistance and you are pregnant, gave birth within the past two months, or are recertifying for children under 21 only. If you want to pursue medical support from a non-custodial parent, you must complete this section.

ABSENT/DECEASED SPOUSE INFORMATION

12 If you are recertifying for Temporary Assistance, Medical Assistance or the Medicare Savings Program, fill out this section. If anyone who is recertifying is married and their husband or wife does *not* live with them, fill out this section as best you can. If you don't know where this person lives now, PRINT their last known address.

ABSENT CHILD INFORMATION

13 If you are recertifying for Temporary Assistance, Medical Assistance or the Medicare Savings Program, fill out this section. If anyone recertifying has a child under 18 living someplace else, please list the parent and child.

TEEN PARENT INFORMATION

14 You must complete this section **only** if you are recertifying for Temporary Assistance. If there are teen parents under the age of 18 in your household who are recertifying for assistance, list their names. If the teen parent's child lives in the household, list the child's name.

PAGE 6 OF THE RECERTIFICATION FORM

INCOME INFORMATION

Check (✓) YES or NO for yourself or anyone who lives with you. For each "Yes" answer, PRINT the dollar ($) amount or value and the name of the person who gets the income.

15 **NOTE: Foster Care Payments and Food Stamp Benefits –** You may choose to include the foster care child or adult in the Food Stamp Benefits household. If you do, any associated foster care payments will **not** be counted as income. All other income or resources of the foster care child will be counted. If you have any questions about this, make sure to ask your worker.

STEP-PARENT/IMMIGRANT SPONSOR INFORMATION

16 Check (✓) YES or NO for yourself, spouse and everyone who is recertifying for assistance. For each "YES" answer, PRINT the name of the person that the answer refers to.

PAGE 7 OF THE RECERTIFICATION FORM

EMPLOYMENT INFORMATION

Complete this page for yourself and for everyone who is recertifying for assistance.

17 **NOTE:** If you are employed, you may still be eligible for Temporary Assistance, Medical Assistance or other health care programs, and/or Food Stamp Benefits and help with paying your child care costs.

PAGE 8 OF THE RECERTIFICATION FORM

EDUCATION/TRAINING INFORMATION

18 Complete this page for yourself and for everyone who is recertifying for assistance. Be sure to answer the question about where your children go to school.

NOTE: If you are recertifying **only** for Medical Assistance, you do not need to fill out this page.

PAGE 9 OF THE RECERTIFICATION FORM

RESOURCES INFORMATION

Check (✓) YES or NO for each question for yourself and everyone who is recertifying for assistance. For each "Yes" answer, PRINT the dollar ($) amount or value and the name of the person who has the resource. **Be sure to list any joint holdings.** Temporary Assistance and Medical Assistance recipients must also answer these questions about **legally responsible relatives. These are people who are required by law to support you financially, such as** your spouse, and if you are under 21, your parents, or step-parents that live with you.

19 **NOTE:** You **do no**t have to fill out this section:

- If you are recertifying **only** for Medical Assistance for children under **19,** or are a pregnant woman.
- If you are recertifying **only** for Food Stamp Benefits, you **do not** have to answer the question on life insurance.

Has Resources Other Than Those Listed Above: Include items such as vacation homes, campers, snowmobiles, boats, etc.

NOTE: It is very important to let your worker know right away if you get or are expecting to get a lump sum. A lump sum is a one time payment, such as an insurance settlement, inheritance, award from a lawsuit or lottery winning. See the LDSS-4148A: "What You Should Know About Your Rights and Responsibilities" for more information about lump sums.

NOTE: If you or your spouse transfer or give away any assets within the 36 months (60 months for transfers to a trust) prior to the first of the month in which you are in receipt of nursing facility services and have submitted an application for Medical Assistance, you may not be eligible to receive nursing facility services or home and community-based waivered services under the Medical Assistance Program.

PAGE 10 OF THE RECERTIFICATION FORM

MEDICAL INFORMATION

20 Check (✓) YES or NO for yourself and everyone who is recertifying for assistance. For each "YES" answer, PRINT the requested information. Be sure to list all health and hospital/accident insurance that you have or that is available to anyone recertifying. Medical Assistance may be able to pay for medical bills for care you were given during the three months before the month you apply for help. If you have already paid the bill, we may be able to pay you for the bill if we determine that you would have been eligible for Medical Assistance at the time. We can pay you even if the doctor or other provider does not accept Medical Assistance, but we can only pay you the amount Medical Assistance pays and only if the bill was for services that Medical Assistance covers.

HEALTH PLAN SELECTION

If you are determined eligible for Family Health Plus, you must select a health plan in order to receive medical care. If you want to keep the doctor you have now, you need to join a health plan that your doctor belongs to. If you want to pick a new doctor or health center, call the plan you want for help. Once enrolled in a health plan, you must use the doctors and hospitals under that plan.

Some people enrolled in Medicaid are required to join a health plan. Others are not. If you or family members are determined eligible for Medicaid and you are in a county that requires people to join a health plan, we will enroll you in the plan you chose, if that plan participates in Medicaid. If you are in a county that does not require people to be in a health plan, we will still enroll you in the plan you chose, unless you tell us that you do not want to be in this plan by checking the box in this section. Your interviewer will discuss this with you.

HEALTH PLAN SELECTION (continued)

After the day you apply **for Medical Assistance, you must make sure the doctor or other provider accepts Medical Assistance before you get medical care.**

PAGE 11 OF THE RECERTIFICATION FORM

SHELTER INFORMATION

21 PRINT the amount you pay for rent, mortgage, room and board or other housing. If you have a mortgage payment, include property taxes, homeowner's insurance (including fire insurance), and assessments in the Shelter Expenses Amount. Check (✓) YES or NO if you or anyone who lives with you pay for heat or other utilities. Be sure to answer the other four shelter questions at the end of this section.

NOTE: If you are unsure about how to answer any questions about your type of housing or the amount of your shelter expenses, ask your worker.

PAGE 12 OF THE RECERTIFICATION FORM

OTHER EXPENSES

22 Check (✓) YES or NO for yourself and everyone who is recertifying for assistance. For each "YES" answer, PRINT a dollar ($) amount.

PAGE 12 OF THE RECERTIFICATION FORM

OTHER INFORMATION

Check (✓) YES or NO for yourself and everyone who is recertifying for assistance.

23 **NOTE:** "U.S. Military" means the:

- U.S. Army
- U.S. Navy
- U.S. Coast Guard
- U.S. Marines
- U.S. Air Force
- U.S. Merchant Marine during World War II

"U.S. Military" also includes Reservists or National Guard members who have ever been called to active duty by the President of the United States

PROPERTY TRANSFER STATUS: Check (✓) the **I have** box or **I have not** box.

NOTE: New York State Law provides for fine or jail, or both, for a person found guilty of obtaining Temporary Assistance, Medical Assistance or Food Stamp Benefits by hiding the facts or not telling the truth.

PAGE 13 OF THE RECERTIFICATION FORM

DO NOT WRITE ON THIS PAGE UNLESS YOU WANT TO CLOSE YOUR CASE FOR ONE OR MORE OF THE PROGRAMS LISTED IN THE TOP RIGHT CORNER OF PAGE 13 OF THE RECERTIFICATION FORM. TO CLOSE YOUR CASE FOR A PROGRAM, PUT A CHECKMARK (✓) IN THE BOX NEXT TO THAT PROGRAM AND SIGN WHERE INDICATED. YOUR CASE WILL ONLY BE CLOSED FOR THE PROGRAM(S) YOU CHECK. BEFORE ASKING FOR YOUR CASE TO BE CLOSED, TALK TO YOUR WORKER. YOU MAY BE ELIGIBLE FOR TRANSITIONAL HELP.

PAGE 14 OF THE RECERTIFICATION FORM

24 **PRIVACY ACT STATEMENT/REIMBURSEMENT OF MEDICAL EXPENSES/SUPPORT/NON-DISCRIMINATION NOTICE:** Read this section carefully or have someone read it to you.

25 **FOOD STAMP BENEFITS AUTHORIZED REPRESENTATIVE:** If you are recertifying for Food Stamp Benefits and you want someone from outside your household to get the Food Stamp Benefits for you or to buy the food for you, PRINT their name, address and telephone number.

When an Authorized Representative is applying on behalf of a Food Stamp Benefits Household that does not reside in an institution, both the Authorized Representative and the Food Stamp Benefits Head of Household must sign.

26 **PENALTIES/FOOD STAMP BENEFITS (FS) PENALTY WARNING:** Read this section carefully or have someone read it to you.

NOTE: New York State Law provides for fine or jail, or both, for a person found guilty of obtaining Temporary Assistance, Medical Assistance, Medicare Savings Program or Food Stamp Benefits by hiding the facts or not telling the truth.

PAGE 15 AND 16 OF THE RECERTIFICATION FORM

27 **ASSIGNMENTS, AUTHORIZATIONS AND CONSENTS:** Read this section carefully or have someone read it to you.

NOTE: For **Lifeline**, Temporary Assistance and Food Stamp applicants/recipients must check (✓) the box, if you ***do not*** authorize the NYS Office of Temporary and Disability Assistance to possibly disclose your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate. Lifeline is the lowest rate available for basic telephone service from telephone service providers.

Medicaid**-only** applicants/recipients must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service.

28 **AUTHORIZATION FOR REIMBURSEMENT FROM SSI:** Read this section carefully or have someone read it to you. If you are recertifying for Temporary Assistance and both husband and wife who live together are recertifying for Temporary Assistance, both must sign the Signature section at the bottom of the page.

NOTE: The Social Security Administration may treat the date you submit this signed authorization to the local department of social services as the date you first become eligible for SSI if you submit an application for initial SSI benefits within the next 60 days.

29 **SIGNATURES:** Read this section carefully or have someone read it to you. New York State Law provides for fine or jail, or both, for a person found guilty of obtaining Temporary Assistance, Medical Assistance, Medicare Savings Program or Food Stamp Benefits by hiding the facts or not telling the truth.

If you are a Food Stamp Benefits Authorized Representative, both you and the applicant must sign and date the signature sections on the bottom of page 16 of the Recertification Form.

Sign your name and date the recertification form. When **both** husband and wife who live together are recertifying for Temporary Assistance or Medical Assistance, **both** must sign. If you are recertifying **just** for Food Stamp Benefits, only one signature is needed. If you have filled out the recertification form for someone else, sign **your name** here and PRINT the date you signed.

NOTICE: Recipients of Temporary Assistance, Medical Assistance, Medicare Savings Program and Food Stamp Benefits, who are not satisfied with the action taken on their recertification, have a right to request a fair hearing by contacting the Office of Administrative Hearings:

in writing: New York State Office of Temporary & Disability Assistance
P.O. Box 1930
Albany, New York 12201

telephone: 1-(800) 342-3334

fax: (518) 473-6735

internet: www.otda.state.ny.us/oah/forms.asp

Information from your recertification will be entered and stored in the Welfare Management System (WMS), a statewide computer system. This system is used to improve the management of the Temporary Assistance, Food Stamps Benefits, Medical Assistance, and Medicare Savings programs and to deter fraud.

NOTE: The last page of this recertification form is an application to register to vote. If you would like help filling out the voter registration form, ask your eligibility examiner. Applying to register or declining to register to vote will not affect the amount of assistance that you will be given by this agency.