TO: Local District Commissioners, Medicaid Directors, Temporary Assistance Directors, CNS Coordinators, and Managed Care Coordinators

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: Family Health Plus Premium Assistance Program: Revised Forms and Guide To Reimburse Co-payments

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Liaison
Upstate (518)474-8887 NYC (212)417-4500

This message is to provide local districts with additional guidance for processing Family Health Plus Premium Assistance Program cases and to distribute revised documents for use with this program.

I. Pharmacy Co-Payment Reimbursements

Districts may find the eMedNY formulary file a useful tool when reimbursing FHPlus Premium Assistance enrollees for drug co-payments. Co-payments for Family Health Plus enrollees are $6.00 for brand-name drugs, $3.00 for generic drugs, $1.00 for diabetic supplies, hearing aid batteries and enteral formulae, and $0.50 for covered over-the-counter drugs. Covered over-the-counter drugs include:

- Insulin and diabetic supplies currently covered as a pharmacy benefit by Medicaid (e.g., insulin syringes, blood glucose test strips, lancets, alcohol swabs)
- Smoking cessation agents, including OTC products
- Select over-the-counter medications covered on the Medicaid Preferred Drug List (Prilosec OTC, loratadine, Zyrtec, Cetirizine)
- Hearing aid batteries
- Enteral formulae
- OTC vitamins

A list of Medicaid reimbursable drugs may be found in eMedNY, under the eMedNY Reference tab. Click on “Drug” and search by the National Drug Code (NDC) or by the drug name. The results page will include a “Generic Product Indicator” column, which indicates whether the drug is brand named or generic. The “Cancel Reason” column indicates if the drug is a Medicaid reimbursable drug. Only drugs with a Cancel Reason code of “0” are reimbursable by Medicaid.

For workers who do not have direct access to eMedNY, use the following IP address to access eMedNY resources on the web: http://www.emedny.org/info/formfile.html. There is a downloadable version of the Medicaid formulary file. Use the drop down to define the Field, and search by NDC, or by description. The results page will include a "Type" column which indicates whether the drug is brand named or generic. "BND" is brand named drug requiring co-payment, "BEX" is a brand named drug that is co-payment exempt, "GEN" is a generic drug requiring co-payment, and "GEX" is a generic drug that is co-payment exempt.

II. Mobius Report: BRMP0010 MA MC/TPHI Monthly report.

For each district, this report lists clients enrolled in Medicaid Managed Care, but who also have third party health insurance (TPHI) posted in eMedNY. Recipients in receipt of TPHI are generally excluded from enrollment in managed care. Districts must: review the report to identify current FHPlus cases (identified in the "Ben-Pkg" field with a code of 70), verify that the insurance is through an employer, and obtain the information needed to determine if the plan includes the standard benefits and is cost effective. If the insurance meets all the criteria for the Family Health Plus Premium Assistance Program, the case should be flipped From FHPlus to FHP PAP. Otherwise, the FHPlus case should be closed for having equivalent insurance, as long as the insurance is not one of the FHPlus excepted benefits.

III. Districts are reminded of the following when creating FHP PAP cases:

- Case Type must be 24 for adults.
- Coverage code must be 20 for adults.
- The Employer Sponsored Insurance must be entered into the commercial screens of the eMedNY Third Party subsystem for each recipient covered by the policy. This includes children of the FHP PAP recipients receiving benefits under that policy.
- EPI code of A must be entered on each individual in the household that is covered by the Employer Sponsored Health Insurance. This includes children on the Case Type 24 or children on their own Case Type 20 who are covered by the parent's insurance. This EPI code applies to Upstate districts only.
- The Policy Source code in eMedNY must be "H" Employer Insurance.
- When writing a pay line, Special Claiming Code of "V" must be entered in WMS. This applies to Upstate districts only as NYC does not use WMS for paying premiums.

IV. There are three attachments to this GIS:

1. The Manual Notice of Decision for Family Health Plus - Premium Assistance Program, OHIP-0011, includes revised discontinue and new denial language. This version replaces Attachment E of 08 OHIP/ADM-01. It is available on the DOH Intranet site.

2. The Employer Sponsored Health Insurance Form Request for Information is reformatted and is now a one page document. Space has been provided for the employer to include a FEIN or Social Security number. This form has been assigned DOH number 4450 and replaces Attachment C of 08 OHIP/ADM-01 and form OHIP-0016. It is available on the DOH Intranet site.

3. The Premium Assistance Program Recipient Brochure has been revised to reflect the alignment of resource levels among Medicaid programs. This version replaces Attachment A of 08 OHIP/ADM-01. This document may also be found on the DOH intranet site.

OHIP-0011 (Rev. 9/08)

NOTICE OF DECISION FOR FAMILY HEALTH PLUS – PREMIUM ASSISTANCE PROGRAM

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	Unit or Worker Name	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP **OR** Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

The Local Department of Social Services (LDSS) has made a decision concerning your eligibility for Family Health Plus Premium Assistance Program.

This Department will:

☐ **ACCEPT** the application dated _____ for (name(s)) _____.

Effective: _____,the premium assistance program will pay $_____ ☐weekly ☐bi-weekly ☐ monthly ☐quarterly

☐ **DENY** the application dated _____ for (name(s)) _____.

The reason for this action is as follows:

☐ It is not cost effective for Medicaid to pay the premium for your employer sponsored health insurance plan.

☐ **CONTINUE** the premium payment for (name(s))_____, effective _____.The premium assistance program will pay $_____☐weekly ☐bi-weekly ☐monthly ☐quarterly

☐ **TAKE NO ACTION** on the application dated _____, since it was withdrawn.

☐ **CHANGE** from Family Health Plus Managed Care to Family Health Plus Premium Assistance Program for (name(s)) _____. You will be disenrolled from _____Health Insurance Plan effective:_____ and enrolled in your Employer's Health Insurance Plan _____,effective: _____.The Premium Assistance Program will pay $_____☐ weekly ☐bi-weekly ☐monthly ☐quarterly

☐ **DISCONTINUE** Premium Assistance Program for (name(s))_____ Effective _____. The **reason** for this action is as follows:

☐ You no longer have access to your employer's health insurance plan; you will be enrolled into the Family Health Plus plan you chose on your application.

☐ You no longer have access to your employer's health insurance plan. You must complete the enclosed Family Health Plus Plan enrollment form and return it within 10 days to the address listed above if you want to receive Family Health Plus benefits.

☐ It is not cost effective for Medicaid to continue paying the premium for your employer sponsored health insurance plan. You must notify us **within 10 days** to tell us if you will remain in the employer sponsored health insurance and pay the cost of the premium yourself. If you fail to respond your coverage will end. If you choose to discontinue your health insurance, you must provide us with written proof of your termination date, and you must choose a Family Health Plus plan **within 10 days** if you want to receive Family Health Plus benefits.

☐ It is not cost effective to continue to pay for your premium.

If this application is being denied or discontinued for financial reasons, the following information explains the calculation of eligibility. The income, resources and allowable deductions/exemptions are as follows:

INCOME		**RESOURCES**	
Gross monthly income	$ _____	Countable resources	$ _____
Deductions	- $ _____	Exemptions	- $ _____
Net monthly income	$ _____	Net resources	$ _____
Allowable standard	$ _____	Allowable standard	$ _____
Excess income	$ _____	Excess resources	$ _____

The law(s) and/or regulation(s) which allow us to do this are SSL 369-ee.

If any of these actions were taken because of financial circumstances, we have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing***. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**

3) **On-Line:** Complete and send the online request form at: **http://www.otda.state.ny.us/oah/forms.asp; OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because: _____

_____

_____

_____

Print Name: _____ Case Number: _____

Address: _____ Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file, which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page 1 of this notice or write us at the address printed at the top of page 1 of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

OHIP-0011 (Rev. 9/08)

AVISO DE DECISIÓN TOMADA CON RELACIÓN AL PROGRAMA DE AYUDA CON PAGOS DE PRIMAS - FAMILY HEALTH PLUS

FECHA DE LA NOTIFICACIÓN:	FECHA DE VIGENCIA:	NOMBRE Y DIRECCIÓN DE LA AGENCIA / CENTRO U OFICINA DEL DISTRITO
№ DE CASO:	UNIDAD O NOMBRE DEL TRABAJADOR SOCIAL	
CASO A NOMBRE DE (y nombre de la persona a cargo, si está presente) Y DOMICILIO		NO. DE TELÉFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA
		Conferencia con la Agencia _____ Audiencias Imparciales Información y asistencia _____ Acceso a los Archivos _____ Información sobre Asesoramiento Legal _____

№ DE OFICINA	№ DE UNIDAD	№ DEL TRABAJADOR DE CASOS	№ UNIDAD O NOMBRE DEL TRABAJADOR	№ DE TELÉFONO

El departamento local de servicios sociales ha tomado una decisión pertinente a su habilitación para recibir beneficios del Programa de Ayuda con los Pagos de Primas de Family Health Plus.

Este departamento tomará la siguiente acción:

☐ **ACEPTARÁ** la solicitud de fecha _____ para (nombre[s]) _____.

A partir del: _____, el programa de ayuda con los pagos de primas pagará $_____

☐ semanalmente ☐ cada dos semanas ☐ mensualmente ☐ trimestralmente

☐ **RECHAZARÁ** la solicitud de fecha _____ para (nombre[s]) _____.

El motivo de esta decisión es el siguiente: ☐ No es eficaz, en función de los costos, que Medicaid continúe pague la prima del seguro médico que usted recibe por parte de su empleador.

☐ **CONTINUARÁ** los pagos de primas para (nombre[s]) _____, a partir del _____. El programa de ayuda con los pagos de primas pagará $_____

☐ semanalmente ☐ cada dos semanas ☐ mensualmente ☐ trimestralmente

☐ **NO SE TOMARÁ DECISIÓN ALGUNA** sobre la solicitud de fecha _____dado que ésta fue retirada.

☐ **CAMBIARÁ** de Cuidados Administrados de Family Health Plus, a Programa de Ayuda con los Pagos de Primas de Family Health Plus para (nombre[s]) _____. Usted será retirada(o) del seguro de salud _____, a partir del _____ y se le inscribirá en el seguro médico de su empleador _____, a partir del: _____. El Programa de Ayuda con los Pagos de Primas pagará $_____

☐ semanalmente ☐ cada dos semanas ☐ mensualmente ☐ trimestralmente

☐ **SUSPENDERÁ** los beneficios del Programa de Ayuda con los Pagos de Primas para (nombre[s]_____

_____a partir del_____. El **motivo** de esta decisión es la siguiente:

☐ Usted ya no tiene acceso al seguro médico de su empleador; a usted se inscribirá en el plan de Family Health Plus que usted seleccionó en la solicitud.

☐ Usted ya no cuenta con un plan de seguro de salud por parte de su empleador. Debe rellenar el formulario adjunto de inscripción en el Plan de Salud Family Health Plus, y devolverlo en los próximos 10 días a la dirección indicada arriba si desea recibir el seguro de salud Family Health Plus.

☐ No es eficaz, en función de los costos, que Medicaid continúe pagando la prima del seguro médico que usted recibe por parte de su empleador. Usted nos debe notificar **dentro de 10 días** si usted decide retener el seguro médico que recibe por parte de su empleador y continuar pagando usted mismo(a) el costo de las primas del seguro. Si usted no responde, cesará su cobertura. Si usted decide suspender su seguro médico, usted debe suministrarnos un comprobante por escrito que muestre la fecha en que la cobertura cesa. Además, usted debe escoger un plan de salud de Family Health Plus **dentro de 10 días** si desea recibir beneficios del seguro médico de Family Health Plus.

☐ No es eficaz, en función de los costos, el continuar pagando su prima.

Si la presente solicitud se rechaza o se suspende por razones económicas, a continuación explicamos cómo se evaluaron los requisitos. El ingreso, los recursos y las deducciones permitidas / excepciones son las siguientes:

INGRESOS		**RECURSOS**	
Ingresos brutos mensuales	$ _____	Recursos contables	$ _____
Deducciones	- $ _____	Exenciones	- $ _____
Ingreso neto mensual	$ _____	Recursos netos	$ _____
Estándar permitido	$ _____	Estándar permitido	$ _____
Ingresos en exceso	$ _____	Recursos en exceso	$ _____

La ley y/o reglamentación que nos permite tomar esta decisión es SSL 369-ee.

Si alguna decisión fue tomada por circunstancias financieras, hemos adjuntado una hoja de cálculo de presupuesto para que usted pueda ver cómo calculamos su habilitación para recibir beneficios.

USTED TIENE EL DERECHO DE APELAR EN CONTRA DE ESTA DECISIÓN.
ASEGÚRESE DE LEER EL DORSO DE ESTA NOTIFICACIÓN PARA INFORMARSE SOBRE CÓMO APELAR EN CONTRA DE ESTA DECISIÓN

DERECHO A UNA CONFERENCIA: usted puede solicitar una conferencia para examinar la decisión tomada. Si desea solicitar una conferencia, hágalo lo más pronto posible. Si en la conferencia nos percatamos que nuestra decisión es incorrecta; o si según la información que usted nos brinde, decidimos modificar la decisión tomada, tomaremos la medida correctiva y le enviaremos una nueva notificación. Puede solicitar una conferencia llamando al número de teléfono que aparece en la primera página de esta notificación o enviándonos una carta a la dirección que aparece en esa misma página. Ese número es solamente para solicitar una conferencia con la agencia ***y no es la manera de solicitar una audiencia imparcial.*** Tiene derecho a una audiencia imparcial aunque solicite una conferencia. Si desea que sus beneficios continúen sin cambios (asistencia ininterrumpida) hasta que se tome una decisión de su caso en la audiencia imparcial, debe solicitar una audiencia imparcial de la manera descrita a continuación. Lea la siguiente información sobre audiencias imparciales.

DERECHO A UNA AUDIENCIA IMPARCIAL: si usted cree que la decisión descrita anteriormente es incorrecta, puede solicitar una audiencia estatal imparcial de las siguientes maneras:

1) **Por teléfono:** llame al número estatal:1 800 -342-3334 (TENGA A MANO ESTA NOTIFICACIÓN CUANDO LLAME)

2) **Por fax:** envíe una copia de esta notificación al (518) 473-6735

3) **Por internet:** rellene una petición electrónica en el siguiente sitio: **http://www.otda.state.ny.us/oah/forms.asp; OR**

4) **Por escrito:** rellene este aviso en su **totalidad** y envíe una copia a: *Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201.* Favor de quedarse con una copia.

☐ Deseo una audiencia imparcial. La decisión de la agencia es incorrecta porque: _____

_____

_____

Nombre en letra de imprenta: _____№ de Caso: _____

Domicilio: _____Teléfono: _____

Firma del Cliente: _____ Fecha: _____

USTED TIENE 60 DÍAS, CONTADOS A PARTIR DE LA FECHA EN ESTA NOTIFICACIÓN, PARA SOLICITAR UNA AUDIENCIA IMPARCIAL

Si usted solicita una audiencia imparcial, el Estado le enviará una notificación informándole dónde y cuándo se llevará a cabo la audiencia. Usted tiene derecho a ser representado por un asesor legal, un pariente, un amigo(a) u otra persona, o de representarse así mismo(a). En la audiencia, usted, su abogado u otro representante tendrán la oportunidad de presentar evidencia escrita y oral que demuestre por qué no se debe tomar la medida, como también la oportunidad de interrogar a toda persona que comparezca a la audiencia. Además, usted tiene el derecho de presentar testigos que avalen su caso. Le sugerimos traer consigo todo documento pertinente que le ayude a avalar su caso, tales como: talonario de cheques de pago, recibos, facturas médicas, facturas de calefacción, comprobantes médicos, cartas, etc.

CONTINUACIÓN DE SUS BENEFICIOS: si usted solicita una audiencia imparcial antes de la fecha de vigencia indicada en esta notificación, continuará recibiendo sus beneficios sin cambios hasta que se tome una decisión en la audiencia imparcial. Sin embargo, si la audiencia no se decide a su favor, podríamos pedirle que nos devuelva la cantidad correspondiente a los beneficios de Asistencia Médica que usted recibió y que no tenía que haber recibido. Si no quiere que esto ocurra, marque la siguiente casilla indicando que no quiere que continúen sus beneficios, y mande esta hoja junto con la petición de audiencia. Si marca la casilla, la medida descrita anteriormente se llevará a cabo en la fecha fijada arriba.

☐ Estoy de acuerdo en que se tome la decisión indicada en esta notificación con respecto a mis beneficios de AsistenciaMédica antes de la decisión de la audiencia imparcial.

ASISTENCIA LEGAL: si necesita asesoría legal gratuita, podría obtenerla llamando al número local de la Sociedad de Ayuda Legal u otra asociación de defensa legal. Puede localizar la Sociedad de Ayuda Legal o un grupo de abogacía en las Páginas Amarillas del directorio telefónico bajo *«Lawyers»* (abogados), o llamando al número que aparece en la primera página de esta notificación.

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: en preparación para la audiencia imparcial, usted tiene derecho a revisar el archivo de su caso. Si nos llama o nos escribe, le brindaremos, sin cargo, copias de documentos contenidos en su archivo; los mismos que entregaremos al funcionario a cargo de la audiencia imparcial. Además, si nos llama o nos escribe, le brindaremos, sin cargo, copias de otros documentos contenidos en su archivo y los cuales usted considere necesarios en preparación para la audiencia imparcial. Si desea solicitar documentos o averiguar la modalidad a seguir para consultar su archivo, llámenos al número de teléfono de Acceso a Archivos que aparece en la parte superior de la página 1 de esta notificación. o mande una carta a la dirección indicada en esa misma página.

Si desea copias de documentos que figuran en su archivo, solicítelas con anticipación. Se le proporcionarán dentro de un lapso de tiempo razonable antes de la fecha fijada para la audiencia. Los documentos se le enviarán por correo sólo si usted específicamente los solicita.

INFORMACIÓN: si desea información adicional sobre su caso, cómo solicitar una audiencia imparcial, cómo consultar su archivo o cómo obtener copias adicionales de documentos, sírvase llamarnos al número de teléfono señalado en la primera página de este aviso o mande una carta a la dirección que figura en esa misma página.

ATENCIÓN: los niños menores de 19 años de edad que no reúnen los requisitos de Child Health Plus A o de algún otro seguro médico, podrían reunir los requisitos del Seguro de Salud Child Health Plus B (Child Health Plus B). El seguro brinda atención y cuidados de salud para niños. Si desea información llame al 1-800-522-5006.

New York State Department of Health
Division of Coverage and Enrollment

EMPLOYER SPONSORED HEALTH INSURANCE REQUEST FOR INFORMATION

Your Employee may be eligible for help in paying for health insurance premiums, please provide information about the health insurance offered by your company and return it to the address at the bottom of this form.

Pursuant to Social Services Law Section 143, all employers of any kind doing business within the State of New York are required to furnish to the social services official, information about employees including information regarding health insurance coverage. Failure to do so may result in court action and penalties.

Employee Last Name:	First Name:
Address:	

Is this individual currently enrolled in health insurance coverage through employment with you?
☐ **YES** Complete Section A ☐ **NO** Complete Section B *
Does this individual have health insurance available to him/her now or in the future through employment with you?
☐ **YES** Complete Section A ☐ **NO** Complete Section B *

SECTION A

Employer Name:	Phone #:
Insurance Carrier/Union Name:	Group #:
Carrier Address:	Carrier Phone #:
Name of person completing form:	Date:

Employee/Enrollee	Coverage Type	Coverage Dates		Monthly Employee Premium Amount $
	Family/Couple/Individual	Start Date	End Date	
1				
2				
3				
4				
5				

What are the standard: Deductibles $_____Co-Insurance $_____Co-payments $_____

Scope of Benefits: Please check all that apply and attach a plan summary

☐ Ambulatory Surgery ☐ Outpatient Services ☐ Durable Medical Equipment ☐ Vision Care/ Eyeglasses ☐ Diagnostic Lab/ X-ray
☐ Inpatient Hospital Services ☐ Physician Services ☐ Transportation - Emergency ☐ Drug and Alcohol treatment ☐ Maternity Care
☐ Emergency Services ☐ Prescription Drug ☐ Dental ☐ Outpatient Mental Health

SECTION B

If employee is NOT enrolled in an employer-sponsored health care plan, check the applicable box and attach the information requested.

☐ Health insurance is not provided to our employees
☐ Employee is not eligible for health care coverage because: _____
_____
_____
_____
☐ Employee is not currently eligible to enroll, but may enroll on (date) _____/_____/_____
☐ Employee is eligible for health insurance, but has not enrolled*****

***Attach the plan(s) summary of benefits the employee, spouse, and dependents may be eligible for; and the employee cost for such benefits.**

If your employee is determined to be eligible to receive premium assistance in paying his/her share of the premium cost, would you accept direct payment from the Department of Social Services? YES___ NO___
If yes, Employer FEIN or Tax ID# is needed _____.

Return this completed form by ___/___/___
Return form to:
Social Service District Name: _____
Address: _____
_____
_____
Or Fax to: _____

For Questions, Call:

Who is Eligible?

You must be a resident of New York State between 19 and 64 years of age,

A United States citizen, national, Native American or an individual with satisfactory immigration status;

Not eligible for Medicaid based on income;

Eligible for, or enrolled in, employer based insurance;

Employer-based insurance includes standard scope of services and is determined to be qualified and cost effective by the department of social services.

You must meet income/resource and eligibility requirements for the Family Health Plus Program.

Co-payment schedule

Individuals enrolled in Family Health Plus are required to pay part of the cost of some medical care/services. If your employer's health insurance plan's co-payments are higher than those below, your physician can bill Medicaid or you can be reimbursed by your local department of social services.

Physician visits	$5.00
Brand Name Prescriptions	$6.00
Generic prescriptions	$3.00
Radiology services	$1.00
Lab tests	$ .50
Non-urgent ER visits	$3.00
Inpatient hospital stay	$25.00
Covered over-the-counter drugs; lancets, test strips, enteral formula	$1.00
smoking cessation products	$ .50
Dental visits (up to a total of $25.00/year)	$5.00

State of New York
Department of Health
Richard F. Daines, M.D., Commissioner
(Revised 05/08)

Family Health Plus

Premium Assistance Program

For individuals who qualify for Family Health Plus and have health insurance available through their employer

Is the Premium Assistance Program as good as Family Health Plus?

Comprehensive Health Care Coverage

Inpatient/outpatient health care

Physician services

Radiation therapy, chemotherapy, hemodialysis

Drug, alcohol, mental health services

Emergency ambulance services

Durable medical equipment

Prescription drugs

Lab tests, x-rays

Vision, speech and hearing services

Rehabilitative services

Hospice

Dental

You will get these benefits either through your Employer's Health Insurance or through your Medicaid benefit.

Are there additional benefits?

The Premium Assistance Program also pays for :

Your share of the Premium for your employer based insurance and

Reimburses for;

Deductibles;

Co-insurance;

Co-payments that exceed the Family Health Plus co-payment schedule.

What happens if I have to wait to join my employer's health insurance?

If you are eligible for this program, but are not yet enrolled in your employer's insurance, you may be enrolled in a Family Health Plus Managed Care Plan temporarily until your employer's insurance enrollment period allows you to sign up.

Children 18 years old and younger will also be evaluated for Medicaid or Child Health Plus while waiting to enroll in your employer's health plan.

Where can I apply?

You may apply using the Access NY Health Care application which can be printed from our website at: www.health.state.ny.us/nysdoh/fhplus/index.htm

Or call our toll free hotline at: 1-877-934-7587.

Or visit your local department of social services.

You may also apply through Facilitated Enrollers, which are available near you.

Call 1-877-934-7587 to find a Facilitated Enroller in your County, or visit: www.health.state.ny.us/nysdoh/fhplus/how_can_I_apply.htm

How do I apply?

You will need to complete an application, provide certain information on income and resources, and complete a personal interview before an eligibility determination can be made.

¿Quién reúne los requisitos?

Usted debe ser residente del Estado de Nueva York y tener entre 19 y 64 años de edad;

Ciudadano estadounidense, nacional, americano autóctono o un individuo con estado migratorio aprobado;

No reunir los requisitos de Medicaid basándose en ingresos;

Reunir los requisitos para inscribirse, o estar inscrito en un seguro de salud patrocinado por el empleador.

El seguro patrocinado por el empleador incluye una gama de servicios estándar, y el departamento de servicios sociales lo considera aceptable y económico.

Usted debe de reunir los requisitos de ingresos y recursos establecidos por el Programa de Family Health Plus.

Tarifa de copagos

Las personas inscritas en Family Health Plus deben de pagar una porción de ciertos costos de servicios y atención médica. Si el monto de los copagos del seguro de salud de su empleador es más alto que los señalados a continuación, su médico puede facturar el seguro de Medicaid o el departamento local de servicios sociales le puede rembolsar a usted los pagos.

Visitas médicas	$5.00
Medicamentos recetados de marca	$6.00
Medicamentos genéricos recetados	$3.00
Servicios de radiología	$1.00
Pruebas de laboratorio	$ .50
Visitas no urgentes a sala de emergencia	$3.00
Atención de paciente interno (hospital)	$25.00
Medicamentos de venta libre comprendidos en el plan; lancetas, tiras reactivas, fórmulas intestinales	$1.00
Productos para cesar el hábito de fumar	$ .50
Visitas al dentista (hasta un total de $25.00/al año)	$5.00

Estado de Nueva York
Departamento de Salud
Richard F. Daines, M.D., Comisionado
(Revised 05/08)

Family Health Plus

Programa de Ayuda con Pagos de Primas

Este programa está disponible para aquellas personas que reúnen los requisitos de Family Health Plus y pueden afiliarse a un seguro de salud patrocinado por el empleador.

¿Es igual de conveniente el Programa de Ayuda con Pagos de Primas que el Programa de Family Health Plus?

Cobertura total de seguro de salud

Atención de salud como paciente interno / externo

Servicios suministrados por un médico

Radioterapia, quimioterapia, hemodiálisis

Servicios de tratamiento de salud mental, drogadicción y alcoholismo

Servicios de emergencia en ambulancia

Equipo médico duradero

Medicamentos recetados

Pruebas de laboratorio, rayos x

Servicios de vista, habla y audición

Servicios de rehabilitación

Cuidados paliativos

Servicios dentales

Usted recibirá estos beneficios ya sea, por medio del seguro de salud de su empleador o por medio de Medicaid.

¿Existen otros beneficios adicionales?

El Programa de Ayuda con Pagos de Primas también paga por:

La porción de su costo de la prima del seguro de salud patrocinado por su empleador y reembolsa por:

Deducibles

Coseguros

Copagos que sobrepasen las tarifas fijadas por Family Health Plus.

¿Qué pasa si tengo que esperar para inscribirme en el seguro de salud de mi empleador?

Si usted reúne los requisitos de este programa, pero todavía no se ha inscrito en el seguro de salud patrocinado por su empleador, usted puede inscribirse temporalmente en el Plan de Cuidados Administrados de Family Health Plus hasta que se habra el próximo periodo de inscripción en el plan de salud de su empleador.

Las personas de 18 años de edad o menor también se les evaluará para ver si pueden recibir Medicaid o Child Health Plus mientras esperan inscribirse en el seguro de salud de su empleador.

¿Dónde puedo solicitarlo?

Usted puede solicitarlo usando la solicitud de *Access NY Health Care*. Puede imprimir la solicitud desde la página web:

www.health.state.ny.us/nysdoh/fhplus/index.htm

O bien llámenos a la línea directa: 1-877-934-7587.

O visite la oficina local de servicios sociales.

Usted también puede solicitarlo por medio de los representantes especializados en el proceso de inscripción de su localidad.

Llame al 1-877-934-7587 para averiguar la ubicación del especialista en su condado, o visite: www.health.state.ny.us/nysdoh/fhplus/how_can_I_apply.htm

¿Cómo lo solicito?

Usted tendrá que rellenar una solicitud, suministrar ciertos datos relativos a ingresos y recursos, y ser entrevistado(a) antes de que tome una decisión.