STATE OF NEW YORK
DEPARTMENT OF HEALTH

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 10 OHIP/ADM-5

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: April 20, 2010

SUBJECT: Revised DOH-4220: Access NY Health Care Application and Release of DOH-4495A: Access NY Supplement A

SUGGESTED DISTRIBUTION:
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ATTACHMENTS:

Attachment I - DOH-4220 (Rev. 2/10), Access NY Health Care Application
Attachment II - DOH-4495A (Rev. 2/10), Access NY Supplement A
Attachment III - Summary of Revisions to DOH-4220, Access NY Health Care Application
Attachment IV - Verification of Employment
Attachment V - Self-Declaration of Income

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
10 OHIP/ADM-4 10 OHIP/ADM-1 03 OMM/ADM-6 09 OHIP/INF-2 06 OMM/INF-1			18 NYCRR 360-2.2		GIS 06 MA/015

I. PURPOSE

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP/ADM) is to familiarize local departments of social services (LDSS) and other users with the revised DOH-4220, Access NY Health Care application (Attachment I) and companion forms. This ADM also introduces the Access NY Supplement A, DOH-4495A (Attachment II), which must be completed in addition to the Access NY Health Care application for certain populations.

In addition, this directive provides guidance on policy changes related to specific questions in the revised Access NY Health Care application. Guidance is also provided for LDSS regarding the use of certain district-specific forms.

II. BACKGROUND

The Access NY Health Care application was revised to support recent changes in policy which eliminate the resource test for non-SSI-Related Medicaid and Family Health Plus (FHPlus) applicants and the requirement for a personal interview for individuals applying for Medicaid and FHPlus coverage. The revised application incorporates information that may have previously been provided during the personal interview.

To simplify the eligibility rules for many applicants/recipients (A/Rs) and LDSS examiners, Sections 58 through 59(d) of Chapter 58 of the Laws of 2009 amended Sections 366 and 369-ee of the Social Services Law to eliminate the resource test for FHPlus and for all Medicaid categories except for the SSI-Related eligibility group. This change was effective January 1, 2010, and was explained in 10 OHIP/ADM-1, “Elimination of the Resource Test for Non-SSI-Related Medicaid/Family Health Plus Applicants/Recipients”.

Chapter 58 of the Laws of 2009 eliminated the requirement to conduct a personal interview as part of the process of determining eligibility for Medicaid and FHPlus as explained in 10 OHIP/ADM-4, “Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants”. This change is intended to eliminate barriers to obtaining public health insurance. Local departments of social services, Facilitated Enrollers (FEs) and deputized workers in designated outreach sites can no longer require applicants to meet with them face-to-face as a condition of eligibility. The application was revised to ensure that information necessary for making an eligibility determination is obtained from the applicant without the personal interview.

III. PROGRAM IMPLICATIONS

A. Access NY Health Care Application

The Access NY Health Care application was revised to be more user-friendly. Certain sections were reformatted and language

was simplified for increased readability. In addition, certain questions were added to aid LDSS examiners in obtaining information necessary to make eligibility determinations, particularly in response to the elimination of the requirement for a personal interview.

Examples of these revisions can be seen in Section A, formerly titled "Contact Information". This section was renamed "Applicant's Information" to make clear to the applicant that his/her information should be provided in this section. Further, "First Name" and "Last Name" were changed to "Legal First Name" and "Legal Last Name" because in many cases applicants were providing nicknames rather than legal names. A SEND PROOF icon was also added throughout the document to assist applicants in understanding when documentation is required.

Questions were added to the revised DOH-4220 to provide useful information to LDSS examiners to assist them in making eligibility determinations. In the "Home Address" field of Section A, a check box was added for applicants to indicate if they are homeless. Check boxes were also added to identify phone numbers as being a home, cell, work or other phone number. A box was also added to this section to provide applicants with the opportunity to identify an authorized representative.

To further aid LDSS examiners in their responsibilities, applicants are asked in Section B, "Household Information," if persons listed in this section have or had public health insurance coverage in the past, what type of public health coverage, and under what Client Identification Number (CIN) or Plan Identification Number, if known. The CIN is being requested in order to potentially reduce the number of duplicate CINs being assigned at application.

Also in Section B of the revised application, "Household Information," the columns were reformatted to increase readability for the applicant and to allow questions to be moved from other areas of the application to this section. The goal of this reformatting was to reduce the number of times an applicant has to write his/her name throughout the application. Wording throughout the application was also simplified. For example, terms which applicants may have had difficulty understanding, such as "head of household," were eliminated.

A significant change to the application is how citizenship and immigration information is gathered on the application. This information is now required in Section B, "Household Information". The applicant is instructed to check one box that broadly indicates his/her current citizenship or immigration status, as well as the statuses of all other applying household members, except pregnant women. The applicant will be able to choose from, "U.S. Citizen," "Immigrant/non-citizen," "Non-immigrant (Visa holder)," and "None of the above". The applicant is still required to send acceptable proof of this information for him/herself and all other applying household members. Local department of social services examiners must continue to review

the documents provided by the applicant to determine citizenship and immigration status. The application refers applicants to the "Documents Needed When You Apply for Health Insurance" which includes a list of documents that provide identity, citizenship and immigration status.

The "Household Income" section (Section C) and the "Health Insurance" section (Section D) were also revised. The formatting was changed to help the applicant read and complete these sections, and questions were added to assist LDSS examiners in collecting information that previously would have been obtained during the interview. For example, a check box was added to the "Household Income" section for applicants to indicate if they are self-employed, and to indicate if they have any income in each of the income categories (earnings from work, unearned income, contributions and/or other).

Section F, "Blind, Disabled, Chronically Ill or Nursing Home Care," was created to identify applicants who are blind, disabled (categorically SSI-Related), chronically ill or in receipt of nursing home care and to direct such applicants to complete Supplement A (see Section III.B. below).

In addition, language was revised to emphasize the need for certain applicant actions. For instance, in Section I, "Health Plan Selection," the language was strengthened to indicate that FHPlus and Child Health Plus (CHPlus) applicants must choose a health plan to receive health services. It also clarifies that most people applying for Medicaid must also choose a health plan, and failure to do so may result in being automatically enrolled in a health plan, unless the applicant(s) is/are determined exempt from health plan enrollment.

The signature lines have been moved to a separate section of the revised application (Section J), rather than being placed after the "Terms, Rights and Responsibilities". This change is intended to increase the visibility of the signature lines to ensure that applicants submit a signed application.

Other general changes to the application include the elimination of references to the "Women, Infants and Children" (WIC) program and to the "Prenatal Care Assistance Program" (PCAP). The Office of Health Insurance Programs learned that the WIC program has a separate application and does not accept the Access NY Health Care application. The PCAP references have been eliminated from the application as a result of the passage of Chapter 484 of the Laws of 2009, which eliminated statutory references to PCAP. However, pregnant women with limited income may still be eligible for presumptive eligibility and free health insurance under Medicaid. Pregnant women who participate in Medicaid will continue to receive a wide range of services designed to ensure a healthy pregnancy, including prenatal visits, health education and specialty medical care.

B. ACCESS NY SUPPLEMENT A, DOH-4495A

The Access NY Supplement A, DOH-4495A (Attachment II) was created to capture information needed to determine Medicaid eligibility for individuals who are or may be categorically SSI-Related. In addition to the Access NY Health Care application, Supplement A must be completed if anyone who is applying is:

- Age 65 or older;
- Certified blind or certified disabled (of any age);
- Not certified disabled but chronically ill; or
- Institutionalized and applying for coverage of nursing home care, including care in a hospital that is equivalent to nursing home care.

IV. REQUIRED ACTION

A. Access NY Health Care Application (DOH-4220)

The revised Access NY Health Care application (DOH-4220) must be in use by June 11, 2010, approximately 60 days from its anticipated date of availability. After this date, all older versions of the Access NY Health Care application should be discarded. However, if an LDSS receives a 5/08 version of the Access NY Health Care application after this date, the district must accept the application.

The revised Access NY Health Care application (Rev. 2/10) should be used for all applicants applying for Medicaid only, including applicants seeking coverage of long-term care services and nursing home care. However, if an LDSS receives the LDSS-2921 application for a Medicaid-only applicant, they must accept the application and cannot require that the DOH-4220 or DOH-4495A also be completed. The LDSS-2921 should continue to be used when an individual is applying for Medicaid and another program, such as Temporary Assistance, Child Care Assistance and/or Food Stamps.

Individuals who are applying for the Medicare Savings Program (MSP) only should continue to complete the DOH-4328, “Application for the Medicare Savings Program”. However, if an individual submits the Access NY Health Care application, it must be accepted and eligibility for the MSP must be determined for all Medicaid and MSP applicants. The Access NY Supplement A does not have to be completed if the person is applying for the MSP only.

Local departments of social services need to be aware of the following revisions (specifically detailed in Attachment III) in the Access NY Health Care application and corresponding policy implications.

1. Section A – Applicant's Information

Section A now allows an applicant to identify another person who should receive copies of Medicaid notices on his/her behalf, and the contact information for that person. The applicant can identify the role of this person to: apply for and/or renew Medicaid; discuss his/her Medicaid application or case, if needed; and/or get copies of notices and agency correspondence. If this section is completed by the applicant and the applicant is the person signing the application, there is no need for him/her to provide a separate document authorizing a representative. However, if the representative is the person signing the application, the LDSS must obtain separate authorization from the applicant or a copy of legal guardianship. This authorization continues until it is revoked by the recipient; a reauthorization is not required at renewal. If an applicant indicates that someone else should get copies of notices and correspondence, the LDSS must also send the notices and correspondence to the applicant.

NOTE: Federal Medicaid regulations provide, in the case of an incompetent or incapacitated individual, for the submission of an application by someone acting responsibly on the individual's behalf. In these situations, a copy of legal guardianship papers is not required nor is a separate document authorizing the representative. The LDSS is authorized to discuss the application/case and send notices and related correspondence to the responsible individual in addition to the applicant.

2. Section B – Household Information

Applicants are asked to list a Client Identification Number (CIN) or an identification number from a plan card, if someone in the case has or had Medicaid/FHPlus or CHPlus coverage in the past. If the applicant does not list a CIN/Plan Identification Number, the LDSS must not deny the application or request the information from the applicant.

In addition, in the revised application, the phrase "not needed for pregnant women" has been removed in the Social Security Number (SSN) column and replaced with "if you have one". This was revised because although a SSN is not required, if one is provided it helps identify whether the applicant is known to the Welfare Management System (WMS) and will reduce the risk of issuing a duplicate CIN. Social Security Numbers are also needed for Resource File Integration (RFI) matches. The policy on SSNs and pregnant women has not changed; the LDSS must not deny a pregnant woman for failure to provide an SSN. Furthermore, although non-applicants are not required to list their SSNs, the wording "Optional for Non-Applicants" was removed above this column. When certain data matches are available in the future, having the non-applicant's SSN may help verify the income of a parent whose child is receiving Medicaid.

3. Section C – Household Income

When an application is submitted and income is listed but no income documentation is provided, a documentation request form must be sent to the applicant requesting the missing documentation (e.g., pay stubs). The applicant must be given at least 10 calendar days to submit the missing documentation. A copy of Attachment IV, Verification of Employment, must be sent with the documentation request form in the event that the applicant does not have pay stubs or receive pay checks. The applicant can give his/her employer the form to complete and it is the applicant's responsibility to return the completed form to the LDSS. Also, if the applicant answered "Yes," to question 5 in Section D, "Health Insurance", the Employer Sponsored Health Insurance Request for Information form (DOH-4450) must be sent to the applicant. If an applicant requests assistance in obtaining income documentation from the employer, the LDSS shall send the Employment Verification form (LDSS-3707) using current procedures. When an applicant indicates he/she is paid in cash because he/she is paid "off the books" and his/her employer refuses to provide a statement of wages, the Self-Declaration of Income form (Attachment V) shall be filled out by the applicant.

In addition to the slight modification of the format of Section C, several questions were added to obtain more information regarding household income. The new questions and policy implications are as follows:

- Question 1, which asks, "Do you or any applying adult in Section B have no income?", is intended to confirm that a legally responsible relative (LRR) listed in Section B does not have income. If the applicant answers "No" but a LRR is listed as having no income, the district should follow-up with the applicant regarding the discrepancy. If the applicant checks "yes" indicating that an LRR does not have income, the LDSS examiner shall not follow-up with the applicant for an explanation. An explanation is only needed if there is no income for the entire household. The applicant has the opportunity to explain this in Question 2, which asks, "If there is no income listed above, please explain how you are living". This information will be used in conjunction with Section E relating to housing expenses and financial maintenance.

- Question 3 of Section C asks, "Have you or anyone who is applying changed jobs or stopped working in the last three months?". If the applicant indicates that he/she lost or changed jobs in the last three months and provides his/her former employer's name, even if this information still appears on the RFI system, the LDSS must accept the information on the application and not require additional documentation (e.g., Employment Verification form, LDSS-3707) from the former employer to prove loss of employment.

- Question 6 asks, "If you are not eligible for Medicaid or Family Health Plus coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only?". This question is asked so that only individuals interested in receiving family planning benefit services are given this coverage.

  Local department of social services examiners are advised that county-specific Family Planning Exclusion Statements should not be used for applicants who apply using the revised Access NY Health Care application (2/10). Section C of the revised DOH-4220 addresses the Family Planning Benefit Program.

4. Section D – Health Insurance

The 5/08 version of the application included a question that asked if anyone who was applying and over the age of 19 was receiving coverage through a federal, State, county, municipal or school-district health benefits plan. This question has been removed in anticipation of implementing the provision to allow State, county, municipal and school district employees to apply for and enroll in FHPlus or the FHPlus Premium Assistance Program. Until this provision is implemented, LDSS examiners should look at pay stubs or other income documentation provided with the application to determine if anyone applying is a public employee.

5. Section E – Housing Expenses

This section was modified to assist the LDSS examiner in determining financial maintenance. Applicants are asked to provide their monthly housing payment, such as rent or mortgage and property taxes (if applicable). Applicants are allowed to attest to housing expenses and should not be asked to document these expenses.

A second new question in this section asks if the applicant pays for water separately, and if so, instructs the applicant to provide a copy of the water bill. The LDSS examiner can only give the additional allowance for a water expense when documentation is received, either with the application or in response to a worker request. This allowance is added to the Medicaid Income Standard to determine Medicaid eligibility for Low Income Families (LIF) and Single Individuals and Childless Couples (S/CC). A worker request for documentation of a water bill shall be made when the additional allowance amount affects eligibility under the LIF and S/CC categories of assistance. If documentation of a water bill is not provided, the applicant must not be denied, but rather he/she must be budgeted without the additional allowance.

A question was also added to Section E asking the applicant to indicate if he/she receives free housing as part of his/her pay. If the applicant answers "Yes," to this question, the

LDSS examiner must count the amount of in-kind income in the Medicaid Budget Logic (MBL) budget. The value counted must be the allowance for shelter with heat in the district-specific Public Assistance Standard of Need. If the applicant documents that the actual fair market value of the housing is less than the district-specific shelter allowance with heat, the LDSS must use the lower amount.

6. Section F – Blind, Disabled, Chronically Ill or Nursing Home Care

Section F was changed from "Housing Expenses" to "Blind, Disabled, Chronically Ill or Nursing Home Care". Applicants are instructed at the beginning of Section F, "if no one applying is Blind, Disabled, Chronically Ill or in a Nursing Home," they may skip Section F and move ahead to Section G.

Question 1 of Section F asks, "Are you, or anyone who lives with you, and is applying, in a residential treatment facility or receiving nursing home care in a hospital, nursing home or other medical institution?". If the applicant answers "Yes," he/she is instructed to finish completing the Access NY Health Care application and to complete Supplement A. Supplement A is discussed in Section IV.B. of this directive. Question 2 asks, "Are you or anyone who lives with you blind, disabled or chronically ill?". If the applicant answers "Yes," he/she is also instructed to finish completing the Access NY Health Care application and to complete Supplement A.

Applicants are also advised that if they are only applying for the Medicare Savings Program, they do not need to complete Supplement A.

NOTE: Applicants who are not certified disabled but chronically ill are instructed to complete Supplement A. Examples of chronically ill are the inability to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months. Supplement A will gather resource information should the chronically ill applicant be determined certified disabled by the State or Local Disability Review Team.

7. Section G – Additional Health Questions

If an applicant indicates that he/she has past medical bills in Question 1, "Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month?", but does not submit copies of the bills, the LDSS must still determine eligibility for the retroactive period only if the district received documentation of income for that period. If eligible for Medicaid coverage, the case is opened retroactively according to current local district procedures.

Question 2 of this section asks if anyone applying has any unpaid medical or prescription bills older than the previous three months. This question has been added in case the applicant is determined to be eligible with excess income and may enroll in the spenddown program. Districts must not require copies of such bills unless the applicant may use them to meet a spenddown.

Question 3 can be used to identify individuals who may have coverage in another county, which the district can facilitate having transferred, pursuant to 08 OHIP/LCM-1, "Continued Medicaid Eligibility for Recipients who Change Residency (Luberto vs. Daines)".

8. Section H – Parent or Spouse Not Living in the Household or Deceased

For individuals applying using the revised Access NY Health Care application (2/10), county-specific absent parent forms must no longer be used. Information that was previously captured on such forms is now included in Section H of the application. In this section the applicant is asked to provide information about the spouse or parent of anyone applying who is deceased or living outside the household. Information obtained in Section H of the Access NY Health Care application shall be used by the LDSS to complete necessary referrals to the Child Support Unit. However, current referral procedures between the Medicaid Unit and the Child Support Unit remain unchanged.

9. Section I – Health Plan Selection

Revisions have been made to this section to emphasize who must enroll in a health plan and how applicants can get information on what plans are available in their county. Applicants are instructed to call the New York Medicaid CHOICE (the managed care enrollment broker for New York State, Maximus) hotline for more information. In districts that do not utilize the enrollment broker, Maximus will refer applicants to the managed care unit in their LDSS. Local departments of social services are reminded that enrollment information must be accepted from Section I. Recipients cannot be required by districts or plans to complete a separate enrollment form. If recipients indicate their preferred primary care doctor in Section I, this information must be sent to the plan by the LDSS.

B. <u>Supplement A (DOH-4495A)</u>

In addition to completing the Access NY Health Care application, applicants who are age 65 or older, certified blind or certified disabled, not certified disabled but chronically ill, or institutionalized and applying for coverage of nursing home care, must complete Supplement A. SSI-Related applicants applying for Medicaid, but not for coverage of community-based long-term care services, may attest to their resources. SSI-Related applicants

applying for Medicaid coverage of community-based long-term care services must submit documentation of the current amount of their resources. These two coverage groups must fill out Sections A through F of Supplement A and sign page 6 of the Supplement. Aged, certified blind or certified disabled applicants who are institutionalized and applying for coverage of nursing home care must complete the entire Supplement and sign the last page of the Supplement. If the LDSS-2921 is submitted, the applicant is not required to complete Supplement A. SSI-Related Medicaid applicants should be encouraged to complete the Access NY Health Care application and Supplement A when they are: age 65 or older; certified blind or certified disabled; not certified disabled but chronically ill; or institutionalized and applying for coverage of nursing home care.

NOTE: In accordance with 10 OHIP/ADM-1, an institutionalized S/CC or ADC-Related applicant who requires temporary nursing home care is budgeted under community rules, and, therefore, is not required to complete Supplement A. If the S/CC or ADC-related applicant has a community spouse, spousal rules apply if the institutionalized spouse is in a medical institution and/or nursing facility and is likely to remain in the facility for at least 30 consecutive days. Under spousal rules there is a resource test and Supplement A must be completed. If an unmarried S/CC or ADC-Related applicant is in permanent absence status in a medical facility, a disability determination must be completed before eligibility can be established for Medicaid coverage of nursing facility services. The applicant is required to complete Supplement A, unless the LDSS-2921 was submitted.

1. Section A – Applicant's Information

Section A asks for the legal name, Social Security Number and marital status of the individual(s) for whom Supplement A is being completed. All other demographics are captured on the Access NY Health Care application.

2. Section B – Blind, Disabled or Chronically Ill

Applicants completing Supplement A are asked three questions regarding their health to assist the LDSS in identifying individuals who are certified blind or chronically ill. This information will help districts identify individuals who should have an Aid to the Disabled (AD) review pursued through the State or Local Disability Review Team. This section also provides information on the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) to help districts identify individuals who may benefit from the MBI-WPD.

3. Section C – Adult Home or Assisted Living Facility

Section C asks if the applicant is living in an adult home or assisted living facility. This information will help districts assure the applicant receives the appropriate income level for budgeting purposes.

4. Section D – Resources/Assets

Section D identifies the type of coverage the applicant can apply for and the required resource documentation, if any, that must be provided for each coverage type. Applicants must check one of the three boxes.

- The first type of coverage is Medicaid coverage without coverage of community-based long-term care services. An applicant may attest to the amount of his/her resources. The applicant is not required to submit resource documentation. This coverage does not include nursing home care, home care or any community-based long-term care services.

- The second type of coverage is Medicaid coverage including coverage of community-based long-term care services. The applicant must submit documentation of the current amount of his/her resources. Services covered under this type of coverage are listed in Section D of Supplement A.

- The third type of Medicaid coverage includes coverage of nursing home care for the institutionalized individual, including care in a hospital that is equivalent to nursing home care. Resource documentation must be submitted back to February 8, 2006, or the past 60 months, whichever is less. If the individual has a trust, documentation of trust assets must be submitted for the past 60 months.

Section D requires the applicant to list all resources owned by the applicant, his/her spouse, and parent(s), including custodial accounts. The questions regarding resources have been moved from the Access NY Health Care application to Supplement A. Applicants who have completed Supplement A must not be required to complete the Long-Term Care Documentation Requirement Checklist (OHIP-0021), the Burial Reserve Acknowledgement (DSS-3827), or the Long-Term Care Change in Need Resource Checklist (DOH-4319).

If the applicant completes the LDSS-2921, the district cannot require the applicant to complete Supplement A. Supplement A can be used instead of the Long-Term Care Change in Need Resource Checklist (DOH-4319) when applicable (see 10 OHIP/ADM-1).

The directions in Section D advise applicants for nursing home care that they must provide an explanation of each bank transaction of $2,000 or more. This amount was determined pursuant to discussions with LDSS and State Department of Health (DOH) Legal staff. Having a set dollar amount statewide will standardize the resource information that must be provided with the application. After reviewing this initial information regarding transactions, the LDSS may request documentation of transfers made during the look-back period. If the district identifies that transfers for less

than fair market value may have been made, districts can still review all transactions made during the transfer look-back period.

5. Section E – Real Property

This section determines if the applicant owns or has a legal interest in any real property that is not his/her primary residence. Ownership of real property is reviewed in order to determine if it is a countable resource.

6. Section F - Homestead

This section is used to determine if a homestead is an exempt resource for Medicaid. A homestead is an exempt resource as long as it is the primary residence of the applicant or certain family members. If the applicant or family member no longer resides in the home, the property is evaluated to determine if it is a countable resource.

If the applicant does not need coverage of nursing home care, he/she is instructed to stop at the end of Section F and to sign the last page of Supplement A. If the applicant needs coverage of nursing home care, he/she must complete Sections G through I and sign the last page of Supplement A.

7. Section G – Applicant Living in a Long-Term Care Facility/ Nursing Home

This section will capture information regarding an applicant’s admission to a long-term care facility/nursing home and includes information on the applicant’s previous address.

8. Section H – Asset Transfers

Section H asks the applicant and the applicant’s spouse if a transfer of assets was made. The applicant should continue to receive the Explanation of the Effect of Transfer of Asset(s) on Medical Assistance Eligibility (LDSS-4294). This informational notice explains how a transfer of assets may affect his/her eligibility. The policies and procedures contained in 06 OMM/ADM-5, “Deficit Reduction Act of 2005 – Long Term Care Medicaid Eligibility Changes,” continue to apply to SSI-Related Medicaid applicants who are eligible for Medicaid coverage of nursing facility services.

9. Section I – Tax Returns

The applicant’s last four years of income tax returns must be submitted, if the applicant and/or his/her spouse filed income tax returns. These tax returns must include 1099s, if applicable, and all schedules and forms.

10. Last Page

The last page (page six) of Supplement A explains the State's policy on liens and recoveries, as well as federal and State laws regarding transfer of assets for less than fair market value, and annuities. The form, Disclosure of Annuities (Attachment VII of 06 OMM/ADM-5) can be eliminated for all individuals who complete and sign Supplement A.

The applicant or his/her representative must sign and date Supplement A. The applicant's spouse must also sign and date Supplement A.

NOTE: If a community applicant who is age 65 or older, certified blind or certified disabled, or not certified disabled is found eligible for Medicaid or FHPlus based on ADC-Related budgeting, eligibility cannot be denied based on the applicant's failure to complete Supplement A. If an S/CC applicant is chronically ill and he/she failed to comply with a disability review or did not complete Supplement A, the applicant cannot be denied coverage if otherwise eligible for Medicaid under an S/CC budget or FHPlus.

C. Application Reprint/Supplement A

An initial supply of the application and Supplement A is being delivered to each LDSS. Following the delivery of this initial supply, the application/Supplement A will be available in the DOH warehouse upon request.

Local departments of social services are reminded that only districts and community-based facilitated enrollment lead agencies may order directly from the DOH warehouse. Health plans performing facilitated enrollment activities are responsible for printing their own supplies of the DOH-4220. It is the responsibility of the LDSS to provide supplies of the DOH-4220 to all other outreach organizations (e.g., hospitals).

V. SYSTEM IMPLICATIONS

None.

VI. EFFECTIVE DATE

The provisions of this ADM are effective May 1, 2010.

Donna Frescatore

Donna Frescatore, Deputy Commissioner
Office of Health Insurance Programs

ACCESS NY HEALTH CARE Medicaid / Family Health Plus / Child Health Plus

PLEASE READ the entire application and INSTRUCTIONS before you fill it out. Print clearly in blue or black ink. An incomplete application cannot be processed and will result in a delay of a decision on your application.

Section A Applicant's Information

Please tell us who you are and how to contact you.

Legal First Name | **Middle Initial** | **Legal Last Name**

Primary Phone # ☐ Home ☐ Cell ☐ Work ☐ Other

Another Phone # ☐ Home ☐ Cell ☐ Work ☐ Other

What Language Do You Speak? _____ **Read?** _____

HOME ADDRESS SEND PROOF
of the persons applying for health insurance
☐ Check here if homeless

Street | **Apt.#**
City | **State** | **Zip Code** | **County**

MAILING ADDRESS
of the persons applying for health insurance if different from above.

Street | **Apt.#**
City | **State** | **Zip Code**

OPTIONAL: If there is another person you would like to receive your Medicaid notices, please provide this person's contact information.
I want this contact person to:

Check all that apply
☐ Apply for and/or renew Medicaid for me
☐ Discuss my Medicaid application or case, if needed
☐ Get notices and correspondence

Name | **State**
Street | **Apt.#** | **Zip Code**
City | **Phone #** ☐ Home ☐ Cell ☐ Work ☐ Other

Section B Household Information

If you live in the household, start with yourself. If you do not, start with any adults who live in the household. List the full legal names of the persons applying for or already receiving Medicaid, Family Health Plus or Child Health Plus **and list the ID Number from their Benefit Card or health plan ID card.** You **must** provide information for household members including: parents, step-parents, and spouses. You may provide information for other household members (for example, a dependent child under the age of 21).
Listing other household members may allow us to give you a higher eligibility level. Pregnant women and children under 19 may be eligible for health insurance regardless of immigration status.

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women SEND PROOF	*Race/ Ethnic Group
01	_____ Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No	SELF	☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
02	_____ Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

SEND PROOF **Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of documents that prove Identity, Citizenship or Immigration Status.**

***Race/Ethnic Group Codes (optional):** A-Asian, B-Black or African-American, I- Native American or Alaskan Native, P- Native Hawaiian or other Pacific Islander, W-White, U-Unknown. Please also tell us if you are Hispanic or Latino-H

NYS DOH (Continued on page 2)

Section B Household Information (Continued from previous page)

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women SEND PROOF	*Race/ Ethnic Group
03	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
04	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
05	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
06	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	
07	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the above	

Is anyone in your household a veteran? ☐ Yes ☐ No If yes, name: _____

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

SEND PROOF **Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of documents that prove Identity, Citizenship or Immigration Status.**

***Race/Ethnic Group Codes (optional):** A-Asian, B-Black or African-American, I- Native American or Alaskan Native, P- Native Hawaiian or other Pacific Islander, W-White, U-Unknown. Please also tell us if you are Hispanic or Latino-H

Section C Household Income

Write the types of money and the amount received by everyone listed in Section B and **SEND PROOF**

Earnings from Work: Includes wages, salaries, commissions, tips, overtime, self-employment. If you are self-employed check here: ☐ Check here if no earnings from work: ☐

Name of Person	Type of Income/Employer Name	How Much? (before taxes)	How Often? (weekly, monthly)

Unearned Income: Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veterans' benefits, Workers' Compensation, child support payments/alimony, rental income, pension, annuities and trust income. Check here if no unearned income: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

Contributions: Money from relatives or friends, roomers or boarders (include money that anyone gives you each month to help meet living expenses). Check here if no contributions: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

Other: Temporary (cash) Assistance, Supplemental Security Income (SSI) payments, student grants, or loans. Check here if none: ☐

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

1. Do you or any applying adult in Section B have no income? ☐ No ☐ Yes Who? _____

2. If there is no income listed above, please explain how you are living:
(For example: living with friend or relative)

3. Have you or anyone who is applying changed jobs or stopped working in the last 3 months? ☐ No ☐ Yes
If yes: Your last job was: Date _____/_____/_____ Name of Employer:

4. Are you or anyone who is applying a student in a vocational, undergraduate, or graduate program? ☐ No ☐ Yes
If yes: ☐ Full Time ☐ Part Time ☐ Undergraduate ☐ Graduate Student's Name:

5. Do you have to pay for childcare (or for care of a disabled adult) in order to work or go to school? ☐ No ☐ Yes

Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? $	How Often? (weekly, every two weeks, monthly)

6. If you are not eligible for Medicaid or Family Health Plus coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only? ☐ No ☐ Yes

Section D Health Insurance

You and your family may still be eligible even if you have other health insurance.

1. Does anyone who is applying have Medicare? ☐ No ☐ Yes **If yes, include a copy of your card (red, white and blue card), for each Medicare beneficiary.** SEND PROOF **Complete the rest of this application and complete Supplement A.**

2. Does anyone who is applying already have other commercial health insurance, including long term care insurance? ☐ No ☐ Yes **If yes, you must send a copy of the front and back of the insurance card with this application.** SEND PROOF

Name of Insured (primary) _____ Persons Covered _____ Cost of Policy _____ End date of coverage, if ending soon _____/_____/_____
Month Day Year

Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do NOT need to complete Supplement A.

3. Is the parent/step-parent of any child applying a public employee who can get family coverage through a state health benefits plan? (see instructions) ☐ No ☐ Yes
If yes, does the public agency where that person works pay all or part of the cost of the health plan? ☐ No ☐ Yes

4. In the past 6 months, has anyone lost or cancelled any type of health insurance that was provided through an employer? ☐ No ☐ Yes (If no, skip to question 5) If yes, what date did you lose coverage? _____/_____/_____
Month Day Year

Your answer to this question will help us understand why people change their health insurance.

Why do the person(s) no longer have the health insurance? (Check only one)

☐ 1. The person who had the insurance no longer works for the employer that provided the insurance.
☐ 2. The employer stopped offering health insurance.
☐ 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent.
☐ 4. The cost of health insurance went up and it was no longer affordable.
☐ 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have.
☐ 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have.

5. Does your current job offer health insurance? **We may be able to help pay for it.** ☐ No ☐ Yes If yes, a "Request for Information Employer Sponsored Health Insurance" form will be sent to you.

Section E Housing Expenses

1. Monthly housing payment **such as rent or mortgage, including property taxes** (just your share). $_____

2. If you pay for water separately how much do you pay? $_____ SEND PROOF How often do you pay? ☐ every month ☐ 2 times a year ☐ quarterly (4 times a year) ☐ once a year

3. Do you receive **free** housing as part of your pay? ☐ No ☐ Yes

Section F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for the applicants.

If no one applying is Blind, Disabled, Chronically Ill or in a Nursing Home STOP please go to Section G.

1. Are you, or anyone who lives with you, and is applying, in a residential treatment facility or receiving **nursing home care** in a hospital, nursing home or other medical institution? ☐ No ☐ Yes
If yes, finish completing this application **AND** complete Supplement A.

2. Are you or anyone who lives with you blind, disabled or chronically ill? ☐ No ☐ Yes If yes, finish completing this application **AND** complete Supplement A.
Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do not need to complete Supplement A.

Section G Additional Health Questions

1. Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you.

☐ No ☐ Yes If yes: Name: _____ In which month(s) of the previous three months do you have medical bills? _____

SEND PROOF **of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and proof of payment.**

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? ☐ No ☐ Yes

3. Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months? ☐ No ☐ Yes

If yes, who? _____ Which state? _____ Which county? _____

4. Does anyone who is applying have a pending lawsuit due to an injury? ☐ No ☐ Yes If yes, who: _____

5. Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)? ☐ No ☐ Yes

If yes, who? _____

Section H Parent or Spouse Not Living in the Household or Deceased

Families who are applying for their children and pregnant women are **NOT** required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information. If you fear physical or emotional harm as a result of providing information about a parent or spouse not living in the home, you may be excused from providing this information. This is called **Good Cause.** You may be asked to show that you have a good reason for your fears.

1. Is the spouse or parent of anyone applying deceased? ☐ No ☐ Yes

If yes, name of applicant with deceased parent or spouse : _____ (If spouse or parent is deceased go to question 3.)

2. Does a parent of any applying child live outside the home? (If no, skip to question 3) ☐ No ☐ Yes

If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box ☐

Child's Name:	**Name of parent living outside the home**	**Current or last known address:**
	_____ Date of Birth (if known): _____/_____/_____	Street: _____ City/State: _____ SSN (if known): _____
Child's Name:	**Name of parent living outside the home**	**Current or last known address:**
	_____ Date of Birth (if known): _____/_____/_____	Street: _____ City/State: _____ SSN (if known): _____

3. Is anyone applying still married to someone who lives outside the home? ☐ No ☐ Yes If yes, name of person applying who is still married: _____

If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box ☐

Legal name of spouse living outside of the home:	**Date of Birth (if known):**	**Current or last known address:**
	_____/_____/_____	Street: _____ City/State: _____ SSN (if known): _____

Section I Health Plan Selection

If you are in receipt of Medicare, STOP skip this section.

IMPORTANT: People with Family Health Plus and Child Health Plus **must** choose a health plan to get their health services. Most people with Medicaid **must** choose a health plan; if you don't choose a health plan you may be automatically enrolled in one unless it is determined you are exempt. **For Medicaid and Family Health Plus:** If you need information about what plans are available in your county, what plans your doctor is in and if you have to join, please call **New York Medicaid CHOICE** at 1-800-505-5678. You can also call or visit your local Department of Social Services. For information about Child Health Plus plans, call 1-800-698-4543. If you already know what plan you want, use this section for your plan choice.

NOTE: If you or family members are found eligible for Medicaid, you will be enrolled in the health plan you choose if it provides Medicaid. If you live in a county that does not require people on Medicaid to join a health plan, you can tell us you do not want to be in a health plan by calling or writing to your local Department of Social Services or by checking this box ☐

Legal Last Name	Legal First Name	Date of Birth	Social Security #	Name of Health Plan You are Enrolling in	Preferred Doctor or Health Center (optional) Check Box if Your Current Provider	OB/GYN (optional)
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	

Section J Signature

I agree to have the information on this application and on the annual renewal shared only among Medicaid, Family Health Plus, Child Health Plus, the health plans indicated in Section I, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Medicaid, Family Health Plus, Child Health Plus, or to evaluate the success of these programs. Each applying adult must sign this application in the space below. By signing this application, I understand that each person applying for Medicaid, Family Health Plus, Child Health Plus, will be enrolled in the appropriate program, if eligible. **I have also read and understand the Terms, Rights and Responsibilities included in this application booklet on the next page.** I certify under penalty of perjury that everything on this application is the truth as best I know.

_____ _____

Date *Signature of adult applicant or authorized representative for the applicant*

_____ _____

Date *Signature of adult applicant or authorized representative for the applicant*

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Family Health Plus, and Child Health Plus. I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid or Family Health Plus, I will tell the social services district. The social services district may be able to help in getting the information.
- If I am applying at a place other than a local department of social services, and my children are not found eligible for Medicaid using this application, I can contact the local department of social services to see if my children are eligible for Medicaid on some other basis.
- I understand that workers from the programs for which family members or I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.
- By applying for Child Health Plus, I agree to pay the applicable premium contribution not paid by New York State.
- I understand that Medicaid, Family Health Plus, and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid or Family Health Plus, I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.
- I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that if my child is on Medicaid or Family Health Plus, 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 local department of social services.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

SOCIAL SECURITY NUMBER

Child Health Plus: SSNs are not required to enroll in Child Health Plus. If available, I will include it for children applying for Child Health Plus.

Medicaid, or Family Health Plus: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within department of social services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

FOR MEDICAID APPLICANTS ONLY

- **Release of Educational Records**
  I give permission to the local department of social services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.
- **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 separtment of social services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

- **Reimbursement of Medical Expenses**
  I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid enrolled providers.

FAMILY HEALTH PLUS AND MEDICAID MANAGED CARE

I understand that in order to receive Family Health Plus benefits, I must join a managed care health plan. I also know that in some counties, joining a health plan may be required to receive Medicaid. I have read how to find out whether my county requires Medicaid enrollees to join a health plan, and how to find out what health plans are available to me in Family Health Plus and in Medicaid managed care. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I/we also understand that if I/we are found eligible for Medicaid instead of Family Health Plus and I/we are in a county that requires Medicaid enrollees to be in a managed care health plan, I/we will be enrolled in the health plan I/we chose unless that health plan does not participate in Medicaid managed care. If I/we are in a county that does not require enrollees to be in a Medicaid managed care health plan, I/we will still be enrolled in the health plan I/we chose unless I/we notify my local social services department in writing, or I/we check the box in Section I, that I/we do not want to be in that plan.

I have read how to find out the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership. I understand that in both Family Health Plus and Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three PCPs in my health plan. I understand that once I enroll in a health plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I understand that if a child is born to me while I am a member of a Medicaid managed care health plan, my child will be enrolled in the same health plan that I am in. I understand that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid managed care, my child will be enrolled in the same health plan that I am in.

- **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 PCP, any other health care provider or the New York State Department of Health (NYSDOH) 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. This may include pharmacy and other medical claims information needed to help manage my care;
  - By my health plan and any health care providers to NYSDOH 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 for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent.

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.

- **Reimbursement of Medical Expenses**
  I understand that if I am determined eligible for Family Health Plus my enrollment will be effective no later than 90 days from the date of submission of a completed application. In the event of an error or delay in my enrollment, Medicaid may be able to reimburse me for reasonable medical expenses I pay as a result of the error or delay. Medicaid may pay my provider for any unpaid expenses only if that provider is a Medicaid enrolled provider.

FOR OFFICE USE ONLY

To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information:	Employed By: (check one)
X _____	☐ Community-Based Facilitated Enrollment Agency ☐ Health Plan ☐ Social Services District ☐ Provider Agency ☐ Qualified Entities Employer Name: _____

To be completed by Facilitated Enrollers

Facilitated Enroller:		Lead Agency/Plan Name:		Lead Org/Plan ID:
Language Used for Application Assistance:	Application Start Date:	Application Sequence Number:	Application Completion Date:	Enter Code of Applying Child: Medicaid _____ CHPlus _____

To be used by the local Social Services District

Eligibility Determined By:	Date:	Eligibility Approved By:		Date:
Center Office:	Application Date:	Unit ID:		Worker ID:
Case Name:	District:	Case Type:		Case #:
Effective Date:	MA Disposition Reason Code: ☐ Denial Code ☐ Withdrawal	Proxy: ☐ Yes ☐ No	Registry #:	Ver:

To be used by Child Health Plus Plans

CHPlus Disposition: ☐ Approved ☐ Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):

HEALTH INSURANCE Medicaid Family Health Plus Child Health Plus

Health Insurance

Health insurance is available for most uninsured children under age 19, living in New York State under one of two programs: Medicaid or Child Health Plus. Almost all children are eligible, regardless of how much your family earns or your child's immigration status.

Health insurance is available under Medicaid and Family Health Plus for most people aged 19 to 64, who have limited income and who are citizens or fall within one of many immigration categories. Also, for people who are age 65 or older, certified blind or certified disabled who have limited income and resources and who are citizens or who fall within one of many immigration categories, health insurance is available under Medicaid.

What programs am I eligible for?

One application is used to apply for the following programs: Medicaid, Family Health Plus, Child Health Plus, and the Family Planning Benefit Program. Based on the information you give us, we will tell you which program you and/or your children may be eligible for.

What services are covered?

Important services such as regular medical check-ups, prescription drugs, hospital care, eye exams, eyeglasses, mental health services, and much more are covered. Medicaid and Family Health Plus have an added guarantee for persons under the age of 21, that provides for all necessary treatment through the Child/Teen Health Program. There are no deductibles or co-payments for children's health insurance.

The chart below shows the amount of income (before taxes) at which you can get free or subsidized health insurance. For children under 19, if your income is more than these amounts, your child can get health insurance for a higher cost.

MONTHLY INCOME LIMITS				RESOURCE LIMITS
FAMILY SIZE	ADULTS	CHILDREN UNDER AGE 19	PREGNANT WOMEN	PERSONS AGE 65 OR OLDER CERTIFIED BLIND OR CERTIFIED DISABLED ONLY
1	$903	$3,610	*	$13,800
2	$1,822	$4,857	$2,429	$20,100
3	$2,289	$6,104	$3,052	$23,115
4	$2,757	$7,350	$3,675	$26,130
5	$3,224	$8,597	$4,299	$29,145
6	$3,692	$9,844	$4,922	$32,160
7	$4,159	$11,090	$5,545	$35,175
8	$4,627	$12,337	$6,169	$38,190

Note: Effective January 1, 2009. Income levels change annually. This is just a guide. Adults without children may have a lower income level. *Pregnant women count as 2 when determining family size.

Do I have to pay anything to join?

How much you pay depends on your family income. For most families, health insurance is free. Other families have to pay a small amount.

How will I get my medical services?

People eligible for Family Health Plus and Child Health Plus will receive their health care through health plans that have their own groups of doctors and hospitals. Before joining a plan, make sure your doctors are a part of that plan.

Most people eligible for Medicaid MUST also choose a health plan. They will receive their health care through the health plan. In some areas of the state there may not be health plans. In these areas, people may go to any doctor who accepts Medicaid. You should talk to your doctor about what kind of health insurance he/she accepts.

What do I have to do to enroll?

It's now easier than ever to apply for health insurance. There are a lot of places in your neighborhood where you can get help. These places have experienced and friendly staff that are available on weekends and evenings to answer all of your questions and help you apply.

It is no longer necessary to have a personal interview to enroll in Medicaid or Family Health Plus. Your completed application can be mailed to or dropped off at your local department of social services. If you are only applying for Child Health Plus, you can mail your completed application directly to a Child Health Plus health plan.

What is available for pregnant women?

New York State provides free health insurance under Medicaid for many pregnant women with limited income regardless of their immigration status. Pregnant women who participate in Medicaid can receive a wide range of services designed to ensure a healthy pregnancy, including prenatal visits, health education, and specialty medical care. Services continue until two months after the pregnancy ends. Family planning services are available for up to 24 months after the pregnancy ends. After the baby is born, he or she will automatically receive health insurance for a year.

What is the Family Planning Benefit Program?

This program covers health services and related drugs and supplies to maintain good reproductive health. Men and women of childbearing age may be eligible.

For Help Call:

To learn the nearest location where application assistance is available in your area, call:

For adults: 1-877-9FHPLUS
For children: 1-800-698-4543

CHILD HEALTH PLUS PREMIUM							
Family Size	Free	$9 per Child per Month (max $27)	$15 per Child per Month (max $45)	$30 per Child per Month (max $90)*	$45 per Child per Month (max $135)*	$60 per Child per Month (max $180)*	Full Premium per Child
1	$1,443	$2,004	$2,257	$2,708	$3,159	$3,610	OVER $3,610
2	$1,942	$2,696	$3,036	$3,643	$4,250	$4,857	OVER $4,857
3	$2,441	$3,388	$3,815	$4,578	$5,341	$6,104	OVER $6,104
4	$2,939	$4,080	$4,594	$5,513	$6,432	$7,350	OVER $7,350
5	$3,438	$4,772	$5,373	$6,448	$7,523	$8,597	OVER $8,597
For each additional person Add:	$499	$692	$780	$935	$1091	$1247	

*Effective July 1, 2009. Income levels change annually. Note that coverage for children under age one is free at higher income levels.

■Seguro médico

El seguro médico se ofrece a la mayoría de los niños no asegurados menores de 19 años, que viven en el estado de Nueva York por medio de uno de dos programas: Medicaid o Child Health Plus. Casi todos los niños son elegibles, sin tener en cuenta cuánto gana su familia o cuál es la condición de inmigración de su niño.

El seguro médico está disponible a través de Medicaid y Family Health Plus para la mayoría de las personas de entre 19 y 64 años de edad que tienen ingresos limitados y son ciudadanos o corresponden a una de muchas categoría inmigratorias. Asimismo, para las personas de 65 o más años, las personas ciegas certificadas o discapacitadas certificadas con ingresos y recursos limitados, y que son ciudadanos o corresponden a una de muchas categorías inmigratorias, el seguro médico se ofrece a través de Medicaid.

■¿Para qué programas soy elegible?

Se utiliza una sola solicitud para los siguientes programas:
Child Health Plus, Family Health Plus, Medicaid y el Programa de Beneficios de Planificación Familiar. Según la información que nos proporcione, le diremos cuál es el programa para el cual usted y/o sus niños podrían ser elegibles.

■¿Cuáles son los servicios cubiertos?

Se cubren servicios importantes, como controles médicos periódicos, medicamentos recetados, atención hospitalaria, exámenes de la vista, anteojos, servicios de salud mental, y muchos más. Los programas Medicaid y Family Health Plus ofrecen una garantía adicional para las personas menores de 21 años que cubre todos los tratamientos necesarios por medio de Child/Teen Health Program. No hay deducibles ni copagos en el seguro médico para niños.

El cuadro que sigue muestra la cantidad de ingresos (antes de impuestos) con los que puede obtener seguro de salud gratis o subsidiado. Para niños menores de 19 años, si su ingreso supera estos montos, su hijo puede obtener seguro de salud por un costo mayor.

LÍMITES DE INGRESOS MENSUALES				LÍMITES DE RECURSOS
FAMILIA TAMAÑO	ADULTOS	NIÑOS MENORES DE 19 AÑOS	MUJERES EMBARAZADAS	PERSONAS DE 65 AÑOS O MÁS SÓLO CIEGOS CERTIFICADOS O DISCAPACITADOS CERTIFICADOS
1	$903	$3,610	*	$13,800
2	$1,822	$4,857	$2,429	$20,100
3	$2,289	$6,104	$3,052	$23,115
4	$2,757	$7,350	$3,675	$26,130
5	$3,224	$8,597	$4,299	$29,145
6	$3,692	$9,844	$4,922	$32,160
7	$4,159	$11,090	$5,545	$35,175
8	$4,627	$12,337	$6,169	$38,190

Nota: Vigente a partir del 1 de enero de 2009. Los niveles de ingresos cambian cada año. Esta es solamente una guía. Los adultos sin niños pueden tener niveles de ingreso más bajos. *Las mujeres embarazadas cuentan como como dos para determinar el tamaño de la familia.

■¿Cuánto debo pagar para participar?

El costo que usted debe pagar depende de sus ingresos familiares. Para la mayoría de las familias, el seguro médico es gratuito. Otras familias deben pagar una pequeña suma.

■¿Cómo recibiré los servicios médicos?

Las personas elegibles para Family Health Plus y Child Health Plus recibirán la atención médica a través de planes de seguro médico con sus propios grupos de médicos y hospitales. Antes de unirse a un plan, asegúrese de que sus médicos pertenezcan al plan.

La mayoría de las personas elegibles para Medicaid DEBEN, además, elegir un plan médico. Recibirán su atención médica a través del plan médico. En algunas zonas del estado, es posible que no haya planes médicos. En estas zonas, las personas pueden acudir a cualquier médico que acepte Medicaid. Debe hablar con su médico para averiguar qué tipo de seguro acepta.

■¿Qué debo hacer para inscribirme?

La solicitud para seguro médico es ahora más fácil que nunca. Hay muchos lugares en su vecindario donde puede obtener ayuda. Estos lugares cuentan con personal amable y experimentado que está disponible los fines de semana y por las tardes para responder a todas sus preguntas y ayudarle con su solicitud.

Ya no es necesario tener una entrevista personal para inscribirse en Family Health Plus o Medicaid. Puede enviar su solicitud completa por correo o entregarla personalmente en el departamento de servicios sociales de su localidad. Si solicita únicamente Child Health Plus, puede enviar su solicitud llena por correo directamente al plan médico Child Health Plus.

■¿Qué programas están disponibles para las mujeres embarazadas?

El Estado de Nueva York ofrece seguro médico gratuito a través de Medicaid para muchas mujeres embarazadas con ingresos limitados, independientemente de su condición de inmigración. Las mujeres embarazadas que participan en Medicaid pueden recibir una variedad de servicios diseñados para asegurar un embarazo sano, como visitas prenatales, educación sobre la salud y cuidado médico especializado. Los servicios continúan hasta dos meses después del fin del embarazo. Los servicios de planificación familiar están disponibles hasta 24 meses después de que termine el embarazo. Una vez que nazca el bebé, él o ella automáticamente recibirá seguro médico por un año.

■¿Qué es el Programa de beneficios de planificación familiar?

Este programa cubre servicios de salud, medicamentos y suministros para mantener la salud reproductiva. Hombres y mujeres en edad fértil pueden ser eligibles.

■Llame si necesita ayuda:

Para averiguar la sede más cercana donde se presta asistencia con la solicitud en su zona, llame:

Para adultos: 1-877-9FHPLUS
Para niños: 1-800-698-4543

PRIMAS PARA CHILD HEALTH PLUS							
Familia Tamaño	Gratis	$9 por niño por mes (máx. $27)	$15 por niño por mes (máx. $45)	$30 por niño por mes (máx. $90)*	$45 por niño por mes (máx. $135)*	$60 por niño por mes (máx. $180)*	Prima total por niño
1	$1,443	$2,004	$2,257	$2,708	$3,159	$3,610	MÁS DE $3,610
2	$1,942	$2,696	$3,036	$3,643	$4,250	$4,857	MÁS DE $4,857
3	$2,441	$3,388	$3,815	$4,578	$5,341	$6,104	MÁS DE $6,104
4	$2,939	$4,080	$4,594	$5,513	$6,432	$7,350	MÁS DE $7,350
5	$3,438	$4,772	$5,373	$6,448	$7,523	$8,597	MÁS DE $8,597
Por cada persona adicional Agregar:	$499	$692	$780	$935	$1091	$1247	

*Vigente a partir del 1 de julio de 2009. Los niveles de ingresos cambian cada año. Tenga en cuenta que la cobertura de niños menores de un año es gratis a niveles de ingresos superiores.

SECTION H Parent or Spouse Not Living in the Household or Deceased

- **If any applicants have an absent spouse or parent, you must complete this section so we can see if medical support is available to you or your child.**
- **Pregnant women do not have to answer these questions until 60 days after the birth of their child.** All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. An example of "good cause" is fear of physical or emotional harm to you or a family member. Question 2 refers to the **PARENT** of any applying child under age 21. Question 3 refers to the **SPOUSE** of anyone applying.
- If the parents are not willing to provide this information, the applying child may still be eligible for Medicaid or Child Health Plus.

SECTION I Health Plan Selection

What is a Health Plan? Applying for programs through Access NY Health Care may mean you get your health care coverage through a Managed Care plan. When you join a plan, you choose one doctor (Primary Care Provider or PCP) from that plan to take care of your regular needs. If you want to keep the doctor you have, you need to pick the plan that works with your doctor. Managed Care health plans focus on preventive care so small problems do not become big ones. If you need a specialist, your PCP will refer you to one.

Who Must Choose a Health Plan? People who are eligible for Family Health Plus and Child Health Plus **MUST** choose a health plan to get medical care. **MOST** people who are eligible for Medicaid **MUST** choose a health plan to get most of their Medicaid benefits. Keep reading to find out how to get more information on this.

How Do I Know What Health Plan to Choose and If I Can Enroll? For Medicaid and Family Health Plus, if you want to find out more about how managed care plans work, if you have to join, and how to choose a plan, call **Medicaid CHOICE** at **1-800-505-5678,** or call or visit your local department of social services. Ask for a Managed Care Education Packet. Information about health plans is also on the NYSDOH website at **www.nyhealth.gov.** You can also enroll by phone, by calling **1-800-505-5678.**

NOTE: If you or a family member are found eligible for Medicaid, and are in a county that does not require people on Medicaid to join a health plan, you will still be enrolled in the health plan you choose if it provides Medicaid, unless you check the box on the application that says you don't want to be enrolled, or tell us you do not want to be enrolled by calling or writing to your local department of social services.

For Child Health Plus:

For information about Child Health Plus plans, call **1-800-698-4543.**

Child Health Plus Premium

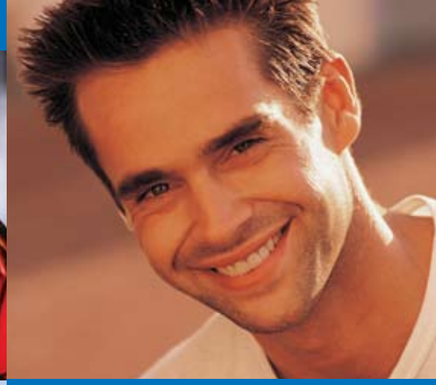
There are no premiums for Medicaid, or Family Health Plus. There may be a monthly premium for Child Health Plus. Use the enclosed chart to determine if you need to pay a premium based on your monthly income. You must include the first month's premium with the completed application or your child will not be enrolled.

SECTION J Signature

Please read the paragraph in this section carefully and read the **Terms, Rights and Responsibilities** section. You must then sign and date the application.

Medicaid | Child Health Plus | family health plus

State of New York
Department of Health



Health Insurance APPLICATION

access NY health care

for Children, Adults and Families

INSTRUCTIONS

CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the Facilitated Enrollers and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.

PURPOSE OF THIS APPLICATION Complete this application if you want health insurance to cover medical expenses. This application can be used to apply for Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or for assistance paying your health insurance premiums. You can apply for yourself and/or immediate family members living with you.

IF YOU NEED HELP COMPLETING THIS APPLICATION DUE TO A DISABILITY, CALL YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES. THEY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATIONS TO ADDRESS YOUR NEEDS.

PLEASE READ the entire application booklet before you begin to fill out the application. If you are applying ONLY for children or if you are a pregnant woman applying alone, you must complete only **Sections A through G and Sections I and J.** Other applicants must complete all sections.

If you are 65 years old or older, certified blind, certified disabled, or institutionalized and applying for coverage of nursing home care, you must **also complete Supplement A.** The supplement includes questions about your resources, such as money in the bank or property you own.

Whenever you see the words **SEND PROOF** on the application refer to the "Documentation Needed When You Apply for Health Insurance" section for a listing of acceptable supporting documents.

HOW TO GET HELP When applying for public health insurance, you **DO NOT** need to visit your local department of social services or a Facilitated Enroller for an interview, but you **MAY** come in or contact a Facilitated Enroller for help filling out this application. **You can get a list of Facilitated Enrollers where you got this application, or by calling 1-800-698-4543. ALL HELP IS FREE.**
(1-877-898-5849 TTY line for the hearing impaired)

SECTION A Applicant's Information

We need to be able to contact the people applying for health insurance. The home address is where the people applying for health insurance live. The mailing address, if different, is where you want us to send health insurance cards and notices about your case. You can also tell us if you want someone else to get information about your case and/or to be able to discuss your case.

SECTION B Household Information

Please include information for everyone who lives with you even if they are not applying for health insurance. It is important that you list everyone who lives with you so that we can make a correct eligibility decision. Include maiden name (legal name before marriage), if this applies to the person. Also include City, State and Country of birth. If a person was born outside of the United States, just write the country of birth. We also need, for each person applying, his/her mother's full maiden name (first and last name). This information may be used to obtain proof of the applicant's birth date under certain circumstances.

- **Is this person pregnant?** If so, when is her baby due to be born? This information helps us determine the size of your family. A pregnant woman counts as two people.
- **Relationship to the person on Line 1.** Explain how each person is related to the person listed on Line 1 (for example, spouse, child, step-child, brother, sister, niece, nephew, etc.)
- **Public Health Coverage.** If you or anyone who lives with you is already enrolled or was previously enrolled in Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or any other form of public assistance such as Food Stamps, we need to know. Also, tell us the identification number on the New York State Benefit Identification Card or plan identification card for Child Health Plus.
- **Social Security Number.** A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank.
- **Citizenship and Immigration Status.** This information is needed only for those people applying for health insurance. Pregnant women do not have to complete this question. To be eligible for health insurance, other persons age 19 and over must be U.S. citizens or be in an eligible immigration category. We need to see either original documentation of U.S. citizenship and identity, or certified copies of these documents. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring these documents. Please note that if you are on Medicare, or receiving Social Security Disability but are not yet eligible for Medicare, it is not necessary to document citizenship or identity.

  Effective July 1, 2010, citizen children who provide their Social Security Number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

  Children who are New York State residents and do not have other health insurance are eligible, regardless of their immigration status.

PUBLIC CHARGE INFORMATION

The United States Citizenship and Immigration Services (USCIS) has stated that enrollment in Medicaid, Family Health Plus, Child Health Plus or the Family Planning Benefit Program CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member, or travel in and out of the country. This is not true if Medicaid pays for long-term care in a place such as a nursing home or psychiatric hospital.

The State will not report any information on this application to the USCIS.

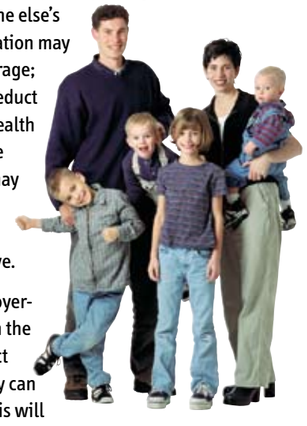
- **Race/Ethnic Group.** This information is optional and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race or ethnic background. You may pick more than one.

SECTION C Household Income (Money Received)

- In this section, list all types of income (money received) and the amounts received by the people you listed in Section B.
- Please tell us how much you make before taxes are taken out.
- If there is no money coming into your home, explain how you are paying for your living expenses, such as food and housing.
- We need to know if you have changed jobs or if you are a student.
- We also need to know if you pay another person or place, such as a day care center, to take care of your children or disabled spouse or parent while you are working or going to school. If you do, we need to know how much you pay. We may be able to deduct some of the amount that you pay for these costs from the amount we count as your income.

SECTION D Health Insurance

It is important to tell us whether anyone applying is covered or could be covered by someone else's health insurance. This information may affect their eligibility for coverage; for some applicants, we can deduct the amount that you pay for health insurance from the amount we count as your income; or we may be able to pay the cost of your health insurance premium if we determine it is cost effective.



Some children who had employer-based health insurance within the past six months may be subject to a waiting period before they can enroll in Child Health Plus. This will depend on your household income and the reason your children lost employer-based coverage.

NOTE: State Health Benefits Plans provide health insurance coverage through the New York State Health Insurance Program (NYSHIP). Coverage is offered to employees/retirees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate in NYSHIP. If you are not sure, check with your employer. If your child has access to State Health Insurance Benefits through NYSHIP, he/she will be ineligible for Child Health Plus coverage.

We may be able to help pay for health insurance premiums if you have or can get insurance through your job. We will need to gather more information about the insurance and will mail an insurance questionnaire to you.

SECTION E Housing Expenses

Write in your monthly cost of housing. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes in the amount you tell us. If you share your housing expenses or your rent is subsidized, please only tell us how much YOU pay toward your rent or mortgage. If you pay for your water, tell us how much you pay and how often.

SECTION F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for each applicant, and what services may be needed. A person with a disability, serious illness or high medical bills may be able to get more health services. You may have a disability if your daily activities are limited because of an illness or condition that has lasted or is expected to last for at least 12 months. If you are blind, disabled, chronically ill or need nursing home care, you will need to complete Supplement A. If neither you nor anyone applying is blind, disabled, chronically ill or in a nursing home, go to Section G.

SECTION G Additional Health Questions

If you have paid or unpaid medical bills from the past three months, Medicaid may be able to pay for these costs. Let us know who these bills are for and in which months. Include copies of the medical bills with this application. Note: This three-month period begins when the local department of social services receives your application or when you meet with a Facilitated Enroller. You will need to tell us what your income was for any past months in which you have medical bills so that we can see if you are eligible during that time. We also ask about where you lived in the past three months, because this may affect our ability to pay for past bills. We ask about any pending lawsuits or health issues caused by someone else so we know if someone else should pay for any portion of your medical care costs.

MORE INSTRUCTIONS ON BACK ▶

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

Your enrollment cannot be completed until all NECESSARY items are received. ***If you need help getting any of these items, let us know.***

YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS. We only need documents that apply to you or others who are applying. We will need to see original or certified copies of documents for identity and U.S. citizenship. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring identity and U.S. citizenship documents. Many local departments of social services and Child Health Plus health plans do not accept original documents by mail, so please check with them if you wish to mail these documents. Copies of other documents can be mailed with your application.

You need to provide proof of Identity, U.S. Citizenship and/or Immigration Status and Date of Birth.

Effective 7/1/10, citizen children who provide a social security number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.
You can provide ONE of the following documents to prove both U.S. Citizenship, Identity and your Date of Birth:

- U.S. passport book/card **OR**
- Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- Certificate of U.S Citizenship (DHS Forms N-560 or N-561) **OR**
- NYS Enhanced Driver's License (EDL).

When one of the above documents is not available, ONE document from EACH of the lists below may be used to prove your citizenship and/or identity.
This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.
Documents with * next to it also show date of birth

U.S. Citizenship

- U.S. Birth Certificate*
- Certification of Birth issued by Department of State (Forms FS-545 or DS-1350)*
- Report of Birth Abroad (FS-240)
- U.S. National ID card (Form I-197 or I-179)
- Native American Tribal Document*
- Religious/School Records*
- Military record of service showing U.S. place of birth
- Final adoption decree
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000

Identity

- State Driver's license or ID card with photo*
- ID card issued by a federal, state, or local government agency
- U.S. Military card or draft record or U.S Coast Guard Merchant Mariner Card
- School ID card with a photo (may also show date of birth)
- Certificate of Degree of Indian blood or other Native American/Alaska Native tribal document with photo
- Verified School, Nursery or Daycare records (for children under 16) (may also show date of birth)
- Clinic, Doctor or Hospital records (for children under 16)*

If you do not use one of the documents that show date of birth, you must also submit one of the following:

- Marriage certificate
- NYS Benefit Identification Card

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you are not a U.S. Citizen

The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status. This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

We need to see **ONE** of the following documents to prove both Immigration Status, Identity and your Date of Birth:
Documents with * next to it also show date of birth

Immigration Status/Identity

- I-551 Permanent Resident Card ("Green Card")*
- I-688B or I-766 Employment Authorization Card*

Immigration Status, but require an additional Identity document

- I-94 Arrival/Departure Record*
- USCIS Form I-797 Notice of Action
- Evidence of Continuous U.S. Residence prior to January 1, 1972

Home Address: This address must match the home address that you write in Section A of the application. The proof must be dated within 6 months of when you signed the application.

- Lease/ letter/ rent receipt with your home address from landlord
- Utility Bill (gas, electric, phone, cable, fuel or water)
- Property tax records or mortgage statement
- Driver's license (if issued in the past 6 months)
- Government ID card with address
- Postmarked envelope or post card (cannot use if sent to a P.O. Box)

PROOF OF CURRENT INCOME, OR INCOME YOU MIGHT GET IN THE FUTURE LIKE UNEMPLOYMENT BENEFITS OR A LAWSUIT: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS, only the ones that apply to you and the people living with you. One proof for each type of income you have is required. Provide the most recent proof of income before taxes and any other deductions. The proof must be dated, include the employee's name and show gross income for the pay period. The proof must be for the last four weeks, whether you get paid weekly, bi-weekly, or monthly. It is important that these be current.

Wages and Salary

- Paycheck stubs
- Letter from employer on company letterhead, signed and dated
- Current signed and dated income tax return and all Schedules
- Business/payroll records

Self-Employment

- Current signed and dated income tax return and all Schedules
- Records of earnings and expenses/business records

Unemployment Benefits

- Award letter/certificate
- Monthly benefit statement from NYS Department of Labor
- Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us)
- Copy of Direct Payment Card with printout
- Correspondence from the NYS Department of Labor

Private Pensions/Annuities

- Statement from pension/annuity

Social Security

- Award letter/certificate
- Annual benefit statement
- Correspondence from Social Security Administration

Workers' Compensation

- Award letter
- Check stub

Child Support/Alimony

- Letter from person providing support
- Letter from court
- Child support/alimony check stub
- Copy of NY Epicard with printout
- Copy of child support account information from **www.newyorkchildsupport.com**
- Copy of bank statement showing direct deposit

Veterans' Benefits

- Award letter
- Benefit check stub
- Correspondence from Veterans Affairs

Military Pay

- Award letter
- Check stub

Income from Rent or Room/Board

- Letter from roomer, boarder, tenant
- Check stub

Interest/Dividends/Royalties

- Recent statement from bank, credit union or financial institution
- Letter from broker
- Letter from agent
- 1099 or tax return (if no other documentation is available)

Support from Other Family Members

- Signed statement or letter from family member

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you pay to have care for your children or parents while you work, provide one of the following:

- Written statement from day care center or other child/adult care provider
- Canceled checks or receipts that show your payments

Proof of health insurance, provide all that apply:

- Proof of current insurance (Insurance policy, Certificate of Insurance or Insurance Card)
- Health Insurance Termination Letter
- Medicare Card (Red, White and Blue Card)

Pregnant women only: proof of pregnancy, provide one of the following:

- Presumptive Eligibility Screening Worksheet for pregnant women completed by a qualified provider that tells us the expected date of delivery
- Statement from medical professional (such as a doctor or nurse practitioner) with the expected date of delivery
- WIC Medical Referral Form that tells us the expected date of delivery

If you have medical bills in the last three months, provide all the following:

For determination of eligibility for medical expenses from the past three months:

- Proof of income for the month(s) in which the expense was incurred
- Proof of residency/home address for the month(s) in which the expense was incurred
- Medical bills for last three months, whether or not you paid them

Access NY Supplement A

This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.
  This includes care in a hospital that is equivalent to nursing home care.

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

INSTRUCTIONS:

- Sections A through F must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections G through I.

A. This Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Social Security Number	Marital Status

Note: The remaining questions are for the person(s) named above.

B. Blind, Disabled or Chronically ill

1. Are you chronically ill? ☐ Yes ☐ No
   (Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)

2. Are you Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
   (If yes, send proof.)

3. If you are disabled and working, are you interested in applying for the MBI-WPD program? ☐ Yes ☐ No
   The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

C. Are you living in an adult home or assisted living facility? ☐ Yes ☐ No

D. Resources/Assets (check the box that applies):

☐ You are applying for Medicaid coverage but not coverage of community-based long-term care services. You may attest to the amount of your resources. You are not required to submit documentation of your resources. This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☐ You are applying for coverage of community-based long-term care services. You must submit documentation of the current amount of your resources.* These services include:

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

Note: Some examples of home and community-based programs that provide waivers and other services are Traumatic Brain Injury Program and Long Term Home Health Care Program.

☐ You are institutionalized and applying for coverage of nursing home care. You must submit documentation of your resources back to February 1, 2006, or the past 60 months, whichever is less.

* You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

List all resources owned by you and/or your spouse/parent(s), including custodial accounts. **If applying for coverage of nursing home care,** also list any accounts closed since February 1, 2006, or in the past 60 months, whichever period is shorter; include balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more. **Note:** Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs):

Bank Name and Account Number	Name of Owner(s)	Current Dollar Amount	Closed Account Balance/ Date Closed
		$	$
		$	$
		$	$
		$	$
		$	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh):

Account Number	Name of Owner(s)	Type/Institution	Current Dollar Amount	Pay Out
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

3. Life Insurance Policies:

Insurance Company	Policy Number	Name of Owner(s)	Cash Value	Face Value
			$	$
			$	$
			$	$
			$	$
			$	$

4. Annuities, Stocks, Bonds, Mutual Funds:

Name of Owner(s)	Company	Date Purchased	Value
			$
			$
			$
			$
			$
			$
			$

5. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the schedule of trust assets.

Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			$		$
			$		$
			$		$

6. Burial Assets/Burial Contracts: (Include copies)

Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have money in a bank account set aside for a burial fund? ☐ Yes ☐ No

If **yes**, in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		$
		$
		$

Do you have life insurance to be used as your burial fund? ☐ Yes ☐ No

If **yes**, what is your policy number(s)? _____

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

Does your spouse have life insurance to be used as a burial fund? ☐ Yes ☐ No

If **yes**, what is the policy number(s)? _____

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles.

Name of Owner(s)	Year/Make/Model	Fair-Market Value	Amount Owed	In Use?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

8. Equity Value in Home:

If you own your home, what is the equity value in your home? $ _____

Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

9. List Any Other Resources:

Resource Type	Name of Owner(s)	Value
		$
		$
		$
		$
		$
		$

E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply) ☐ Yes ☐ No

☐ Rental Property	☐ Vacation Property	☐ Time Share	☐ Vacant Land	☐ Other Property Rights (In or outside of New York State)

If **yes,** please answer the following questions.

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$

F. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No
2. If you are in a medical facility and own your home, do you intend to return to your home? ☐ Yes ☐ No
3. If **no,** is anyone living in the home? ☐ Yes ☐ No

Who is living in the home? _____

How is this person related to you and/or your spouse? _____

If you and/or your spouse's child (of any age) is living in the home, is the child disabled? ☐ Yes ☐ No

Note: If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility.

STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, the last page of this document MUST be signed.

G. Applicant Living in a Long-Term Care Facility/Nursing Home

Name of Facility	Date Admitted / /	Telephone Number ( )	
Street Address	City	State	Zip
Applicant's Previous Address	City	State	Zip

H. Asset Transfers

1. Transfers

a. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

b. Are you in the process of selling property? ☐ Yes ☐ No

c. Did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No
If **yes,** when? _____

d. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

e. Did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No
If **yes,** when? _____

f. Did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No
If **yes,** when? _____

2. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust? ☐ Yes ☐ No

If you answered yes to any of the questions above, explain the transfer(s) below. Attach additional sheets of paper, if needed.

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			$
			$
			$
			$

3. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? **If yes, send copy of agreement.** ☐ Yes ☐ No

I. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No
If yes, send copies of these returns.

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

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 the transfer of assets look-back period (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 determined otherwise eligible for Medicaid coverage of nursing facility services, may cause the individual to be ineligible for nursing facility services for a period of time.

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse on or after February 8, 2006, may be treated as a transfer unless:

- **The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or**
- **The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.**

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

X _____
SIGNATURE OF APPLICANT/REPRESENTATIVE

X _____
DATE SIGNED

X _____
SIGNATURE OF APPLICANT'S SPOUSE

X _____
DATE SIGNED

Summary of Revisions to DOH-4220, Access NY Health Care Application

The purpose of this document is to familiarize local departments of social services (LDSS) and other users with the revised DOH-4220, Access NY Health Care application and companion forms.

A summary of the revisions follows:

The revision date on the application has been changed from 5/08 to 2/10.

All references to the Prenatal Care Assistance Program (PCAP) and Women, Infants, Children (WIC) have been removed from the application.

The formatting of the application has been changed to landscape while the instructions remain in portrait format.

The DOH-4220D, "Additional Information" page has been eliminated.

DOH-4220-I, Instructions:

- "PURPOSE OF THIS APPLICATION" has been added to this section to describe why an applicant would use this form and how to obtain assistance if needed.

- "PLEASE READ" includes additional information pertaining to Supplement A. It reads, "If you are 65 years old or older, certified blind, certified disabled, or institutionalized and applying for coverage of nursing home care, you must **also complete Supplement A.** The supplement includes questions about your resources, such as money in the bank or property you own."

- Added, "Whenever you see the words SEND PROOF on the application, refer to the 'Documentation Needed When You Apply for Health Insurance' section for a listing of acceptable supporting documents."

- "HOW TO GET HELP" is new and was added to tell the applicant that he/she **does not** need to visit his/her LDSS or Facilitated Enroller (FE) to complete the application process. The applicant may, however, contact the LDSS or an FE for help understanding or completing the application. A toll-free hotline number is also provided for applicants in need of assistance.

DOH-4220, Application:

Section A, *Applicant's Information*:

- The title of this section has been changed from "Contact Information" to "Applicant's Information".

- The word “Legal” has been added to all first and last name requests in this section and throughout the application.

- The word “Primary” was added to “Phone #” and a list of check boxes was added to define whether the phone number is “Home”, “Cell”, “Work” or “Other”.

- Evening phone has been changed to “Another Phone #” and a list of check boxes was added to define if the additional phone number is “Home”, “Cell”, “Work” or “Other”.

- “Primary Language Spoken” and “Primary Language Read” have been changed to, “What Language Do You Speak? Read?”.

- A SEND PROOF box has been added to the “Home Address” field, as well as a check box that reads, “Check here if homeless”.

- The second request for a mailing address has been changed to an “Optional” section to give the applicant the option of designating an additional contact person to receive correspondence, discuss the application, or to apply or renew on his/her behalf.

Section B, *Household Information*:

- Removed the “City” and “State of Birth” column and moved that information under each applicant’s name with the addition of “Country of Birth”.

- SEND PROOF has been added to the Date of Birth column.

- The next column reads, “Is this person applying for health insurance?”.

- Added in the next column to the question, “Is this person pregnant?”, is a SEND PROOF notation and a line for the due date of the pregnant woman.

- “Relationship to Head of Household”, has been changed to, “What is the relationship to the person in Box 1?”. “Head of Household” has been changed to, “Self”.

- Added a column that asks, “If this person has or had public health insurance in the past, check the box that applies.” Check boxes were added for the applicant to select, “Child Health Plus”, “Medicaid” or “Family Health Plus”, and a space was added for the applicant to provide “ID Number from Benefit Card/Plan Card, if known”.

- “Optional for Non-Applicants” has been removed as a header over the Social Security Number box. “Social Security Number (if available) Not needed for

pregnant women" has been changed to, "Social Security Number (if you have one)".

- The citizenship section (previously Section D) of the application has been removed. It is now a column in Section B and asks for current citizenship or immigration status. The SEND PROOF notation and, "Not needed for pregnant women", were added.

- A footnote was added that reads, "Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus."

- A footnote was added to refer applicants to the "Documents Needed When You Apply for Health Insurance" which includes a list of documents that provide identity, citizenship and immigration status.

- The last column in this section is "Race/Ethnic Group" with an asterisk that refers to a footnote indicating that this information is optional.

Section C, *Household Income*:

- This section has been changed from "Health Insurance" to "Household Income".

- Each section, "Earnings from Work", "Unearned Income", "Contributions" and "Other", has been expanded to create space for four people per type of income. A check box was added to each income section so the applicant can check if there is no income.

- Added, "Do you or any applying adult in Section B have no income? Yes__ No__ Who?____".

- "If no income, please explain", was changed to, "If there is no income listed above, please explain how you are living. (For example: living with a friend or relative)".

- Added, "Have you or anyone who is applying changed jobs or stopped working in the last 3 months? No__ Yes___ If yes: Your last job was: Date __/__/__ Name of Employer: ____".

- Added, "Are you or anyone who is applying a student in a vocational, under graduate, or graduate program? No__ Yes__ If yes: __Full Time __Part Time___Undergraduate___Graduate _____Student's name:___".

- Added, "If you are not eligible for Medicaid or Family Health Plus coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only? __No __ Yes".

Section D, *Health Insurance*:

- This section was changed from "Citizenship" to "Health Insurance".

- Question 1 in the previous "Health Insurance" section (Section C), which asked, "Does anyone in the household already get Medicaid, Family Health Plus, Child Health Plus or PCAP?", was deleted.

- Question 2, regarding Medicare, is now Question 1. "Medicare #" was deleted. Text was added that reads, "If yes, include a copy of your card (red, white, and blue card), for each Medicare beneficiary. SEND PROOF Complete the rest of this application and complete Supplement A."

- "Does anyone who is applying already have other health insurance?", was changed to, "Does anyone who is applying already have other commercial health insurance, including long term care insurance? __No __Yes If yes, you must send a copy of the front and back of the insurance card with this application. SEND PROOF".

- Added, "Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do NOT need to complete Supplement A."

- The question was deleted that read, "Can anyone over age 19 get coverage through a federal, state, county, municipal or school district health benefits plan? _Yes _No If Yes, Name____ Employed by_____".

- The following question was moved from the "Income" section to the "Health Insurance section": "Does your current job offer health insurance? We may be able to help pay for it. __No __Yes If yes, a 'Request for Information Employer Sponsored Health Insurance' form will be sent to you."

Section E, *Housing Expense*:

- "Monthly housing payment" has been changed to "Monthly housing payment such as rent or mortgage, including property taxes (just your share). $_____".

- The questions, "Type of heat (gas, oil, etc.)" and "Is heat included in your housing payment? __Yes __No", have been deleted.

- Added, "If you pay for water separately how much do you pay? $___ SEND PROOF How often do you pay? _every month _ 2 times a year _quarterly (4 times a year) _once a year".

- Added, "Do you receive free housing as part of your pay? _No _Yes".

Section F, *Blind, Disabled, Chronically Ill or Nursing Home Care*:

- Section G, "Illness/Injury", has been changed and the questions have been divided into two sections, Section F, "Blind, Disabled, Chronically Ill or Nursing Home Care," and Section G, "Additional Health Questions".

- Added, "If no one applying is Blind, Disabled, Chronically Ill or in a Nursing Home STOP please go to Section G."

- Added, "Are you, or anyone who lives with you, and is applying, in a residential treatment facility or receiving nursing home care in a hospital, nursing home or other medical institution? _No _ Yes If yes, finish completing this application AND complete Supplement A."

- "Is anyone who is applying blind, disabled, handicapped, or have a chronic illness or special health care need? _Yes _ No If yes Names:___", has been changed to, "Are you or anyone who lives with you blind, disabled or chronically ill? _No _Yes If yes, finish completing this application AND complete Supplement A."

- Added, "Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do not need to complete Supplement A."

Section G, *Additional Health Questions*:

- Added, "Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you. __No __Yes If yes: Name: __ In which month(s) of the previous three months do you have medical bills? ___ SEND PROOF of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and proof of payment."

- Added, "Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? __No __ Yes".

- Added, "Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months? __No__Yes If yes, who?____Which state?____Which county?_____".

- Added, "Does anyone who is applying have a pending lawsuit due to an injury? __No ___ Yes If yes, who:_____".

- Added, "Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)? __No__Yes If yes, who?____".

Section H, *Parent or Spouse Not Living in the Household or Deceased*:

- Section H was previously the WIC section. All references to WIC have been deleted.

- Added, "Is the spouse or parent of anyone applying deceased? __No__Yes If yes, name of applicant with deceased parent or spouse:_____(If spouse or parent is deceased go to question 3.)".

- Added, "If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box __".

- The question, "Does a spouse (husband or wife) of anyone applying live outside the home?", has been changed to, "Is anyone applying still married to someone who lives outside the home? __No ___Yes If yes, name of person applying who is still married:____".

- Added, "If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box ___".

- Boxes were added for the following items: "Child's Name"; "Name of parent living outside the home"; "Date of Birth (if known)"; "Current or last known address"; "SSN (if known)"; "Legal name of spouse living outside of the home"; "Date of Birth (if known)"; and "Current or last known address".

Section I, *Health Plan Selection*:

- Section I was previously the resource section. The resource questions have been removed from the DOH-4220 and moved to Supplement A.

- Added, "If you are in receipt of Medicare, STOP skip this section."

- Deleted the column titled "Dentist".

- Added a column titled "OB/GYN (optional)".

Section J, *Signature*:

- The signature lines have been moved to before the "Terms, Rights and Responsibilities".

- "Signature of adult applicant or authorized representative for the applicant" was added under the signature line.

Terms, Rights and Responsibilities:

- All references to WIC and PCAP have been removed.

- Family Health Plus and Medicaid Managed Care: In this section the word "know" has been changed to "understand", and the phrase, "I have been told", has been changed to, "I have read how to find out".

For Office Use Only:

- Added, "Qualified Entities" to the "Employed By: (check one)". Also added a space for "Employer Name: _____".

- In the section, "To be completed by Facilitated Enrollers", the FE is asked to identify "Language Used for Application Assistance".

DOH-4220B, Documents Needed When You Apply for Health Insurance:

- The title "Documentation Checklist for Health Insurance" has been changed to "Documents Needed When You Apply for Health Insurance".

- The section, "Identity and Citizenship or Immigration Status for the Medical Assistance Program", which was the last section of the DOH-4220B, has been moved to the first section and shortened to the most commonly used documents.

- All of the boxes in this section have been changed to bullets.

DOH-4220C, Health Insurance Fact Sheet:

- All references to Nutrition, PCAP and WIC have been removed from the fact sheet.

- Income levels and Child Health Plus Premium levels were revised to reflect the 2009 levels.

NEW YORK STATE DEPARTMENT OF HEALTH

Office of Health Insurance Programs

Verification of Employment

Name: _____ App Reg./Case # : _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

For Office Use Only

To be completed by the employer:

I certify that _____ works for me as _____.
(What do you do?)

This employee is paid each (circle one): Week Two weeks Twice per month

Does the employee have access to New York State Health Insurance? ☐ Yes ☐ No

Does the employee have dependents enrolled in his/her employer sponsored coverage? ☐ Yes ☐ No

Please supply the following information:

Last consecutive weeks	Date paid	Gross pay – Include tips, commissions and bonuses
1		
2		
3		
4		

If no longer employed, date last worked: _____

Business name: _____

Business address: _____

City: _____ State: _____

Zip: _____ Business telephone: _____

Employer's name (please print): _____ Title: _____

Employer's signature: _____ Date: _____

NEW YORK STATE DEPARTMENT OF HEALTH

Office of Health Insurance Programs

Self- Declaration of Income

Name: _____ App Reg./Case # : _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Complete the information below only if you have no other way to document your income. All of the boxes below must be checked and all questions answered. Failure to complete this form may result in denial of your application.

☐ I get paid in cash.

☐ I do not get pay checks.

☐ I do not get pay stubs.

☐ I cannot get a letter from my employer. **Explain why**: _____

_____

My cash income is $_____ How often (weekly, monthly etc.) _____

Current Employer: _____

Applicants/Recipients must read the following and sign below

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for Public Health Insurance Programs. I understand that program officials may verify information on this form. I also understand that if I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

Signature of Applicant: _____ Date: _____

Facilitated Enrollers must read the following and sign below

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me. I did not modify the information in any way. I understand that if I intentionally falsified information on this form or if I assisted the applicant in falsifying any information, I may lose my job and may be prosecuted under State law.

Name: _____ Signature: _____ Date: _____