STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237
www.health.ny.gov

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 11 OHIP/ADM-2

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: March 11, 2011

SUBJECT: Automated Enrollment into the Medicare Savings Program in Upstate New York under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

SUGGESTED DISTRIBUTION:	Local District Commissioners Medicaid Staff Temporary Assistance Staff Staff Development Coordinators Fair Hearing Staff
CONTACT PERSON:	Local District Liaison: Upstate: (518)474-8887 New York City: (212)417-4500
ATTACHMENTS:	Attachment I - DOH-4496, Medicare Savings Program Request for Information Attachment II - OHIP-0037, Option to Receive Medicare Savings Program (MSP) Benefit Attachment III - OHIP-0026, Explanation of the Excess Income Program Attachment IV - OHIP-0035, Request for Information Cover Letter Attachment V - OHIP-0014, Notice of Transition of Your MA/FHP/FHP-PAP/FPBP and/or MSP Coverage (County A) Attachment VI – OHIP-0015, Notice of Transition of Your MA/FHP/FHP-PAP/FPBP and/or MSP Coverage (County B) Attachment VII – OHIP-0051, Notice of Medicare Savings Program Case Opened in Error

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
10 OHIP/ADM-3 08 OHIP/ADM-4 05 OMM/ADM-5 10 OHIP/INF-3			Sec. 1144. [42 U.S.C. 1320b-14]of the Social Security Act PL 110-275, Section 113		08 OHIP/LCM-1 GIS 05 MA/024 GIS 04 MA/013

I. Purpose

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP/ADM) is to advise local departments of social services (LDSS) of changes to the implementation of Section 113 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which requires applications for the federal Low Income Subsidy program to be considered an application for the Medicare Savings Program (MSP).

II. BACKGROUND

The Low Income Subsidy (also known as "Extra Help") is a Medicare benefit program administered by the Social Security Administration (SSA) to help low income Medicare beneficiaries pay for prescription drug costs associated with their Medicare Part D benefits. The Medicare Savings Program is a Medicaid benefit that helps Medicare beneficiaries pay for costs associated with Medicare Part A and Part B. As part of an effort to decrease barriers to enrollment, Section 113 of the MIPPA states that an application to SSA for the Low Income Subsidy (LIS) program for Medicare Part D benefits will also be used to initiate an application for benefits under the Medicare Savings Program. This statutory requirement is intended to improve enrollment in both the Medicare Part D Low Income Subsidy program, administered by the Social Security Administration, and the Medicare Savings Program, administered by the states.

III. PROGRAM IMPLICATIONS

Beginning January 1, 2010, with the consent of the applicant, SSA began transmitting data received from the LIS "Extra Help" application to the State for consideration of the applicant's eligibility for the Medicare Savings Program. The State receives this information via an electronic file from SSA each day that SSA makes LIS eligibility determinations. This data must be treated as if the individual had applied for the MSP directly to the Medicaid program.

To minimize the workload this increase in MSP applications has created for local departments of social services, the New York State Department of Health (NYSDOH) is automating as much of the application process as possible. By automating this process, the LDSS are relieved of the responsibility for review and determination of benefits for the majority of MSP applications received from SSA.

Upon receipt of the file from SSA, each application will be matched against the Welfare Management System (WMS). If a Client Identification Number (CIN) exists in WMS for the individual, it will be used to register the application, barring certain circumstances. When a match in WMS is not found, a CIN will be generated for the applicant. Once the application is registered, it will be automatically accepted or denied, or listed on an Exception Report for manual processing.

A. Applications Accepted through the Automated Process

Eligible applications from SSA indicating a net income level below 135% of the current Federal Poverty Level (FPL) will trigger an automatic opening of a MSP case by the State, using new opening codes created for this purpose. (Refer to Section VI.) Cases will be authorized based upon the date of application to SSA, not the date the application is received by the State.

The net income level indicated on the SSA file will be compared to the current Federal Poverty Levels to determine the applicant's MSP category: Qualified Medicare Beneficiary (QMB) 100% FPL; Specified Low Income Medicare Beneficiary (SLIMB) 120% FPL; or Qualifying Individual (QI) 135% FPL. Income information will not be stored on the Medicaid Budget Logic (MBL) system.

Note: LIS application data sent by SSA to the State has been verified by SSA and is sufficient for documentation of identity, income, residence and citizenship.

Individuals determined eligible for MSP benefits based on the income information received from SSA will be sent an acceptance notice by the State through the Client Notice System (CNS). The notice will inform the individual of their MSP category. The acceptance notice will include the revised "Medicare Savings Program Request for Information" form (Attachment I), which is designed to collect additional demographic and financial information not collected on the LIS application, or for the recipient to report a change in circumstances.

The "Medicare Savings Program Request for Information" form may be completed by the MSP recipient and returned to the local district. Recipients may use this form to request consideration for retroactive MSP coverage, if applicable, to provide information about other health insurance premiums paid, or to report income information. The recipient will be instructed to return the form to his or her LDSS office, and the LDSS will be responsible for acting on information received on this form in a timely manner. Returning the "Medicare Savings Program Request for Information" form is optional for cases that were opened through the automated process. If the individual does not return the form, they will continue to receive the benefit indicated on their acceptance notice.

Additional financial information provided by the recipient may affect the MSP level of benefits the individual is entitled to receive. If the income reported on the "Medicare Savings Program Request for Information" form supports a different MSP category than the MSP category determined through the automated process, verification of income must be provided prior to changing the MSP level. When a change in MSP category is indicated, the LDSS district must change the MSP code in WMS and in eMedNY and send the appropriate undercare notice.

Recipients may indicate on the returned "Medicare Savings Program Request for Information" form that they are paying health insurance premiums other than Medicare. Health insurance premiums other than Medicare Part B are an allowable income deduction for MSP cases; however, SSA does not collect this information on the LIS application. If the individual indicates and provides proof that they pay such premiums, an MBL budget must be calculated to determine if a change in MSP category is appropriate. If a change in category is indicated, the district must process the change and send the appropriate notice.

Recipients may use the "Medicare Savings Program Request for Information" form to request retroactive MSP benefits. The policy for retroactive MSP benefits has not changed. Individuals eligible for QMB are not entitled to retroactive benefits. Recipients eligible for SLIMB and QI may be entitled to retroactive benefits for three months prior to the date of the LIS application if they are otherwise eligible. Retroactive QI benefits may not be provided for a previous calendar year.

Recipients may indicate on the "Medicare Savings Program Request for Information" form that they would like to apply for full Medicaid benefits. In this case, the local district must send the Access NY Health Care application and Supplement A, if applicable, to the MSP recipient. The recipient must complete the application and comply with all current procedures for applying for Medicaid benefits.

New QMB, SLIMB and QI cases should be selected for annual renewal according to the current renewal process. QI cases will be authorized through 12/31/2049, as they are currently.

Automated eMedNY Implications

The State will enter all necessary transactions in eMedNY to create Medicare coverage and Buy-In date spans for applications accepted through the automated process. For all MSP categories, the "Begin Date" for Medicare Part A and Part B coverage will be the first day of the month of application to SSA for LIS. The Medicare coverage "Begin Date" can be updated by the LDSS if retroactive benefits are authorized.

For individuals found eligible for SLIMB and QI benefits, the MSP Buy-In "Begin Date" will be the first day of the month of application to SSA for LIS. For those found eligible for QMB benefits, the MSP Buy-In "Begin Date" will be the first day of the month following the month of application to SSA for LIS. Buy-In date spans in eMedNY will be generated by the State and can be identified by the Transaction Source Code of "5" (NYSDOH) on the Third Party Resource page.

Through the automated process a non-photo Common Benefit Identification Card (CBIC) will be issued based on the default card code of "N" on screen 5 in WMS to all applicants determined to be eligible for QMB benefits. SLIMB and QI cases will default to a card code of "X" and a CBIC will not be issued. LDSS-3209, "Application Turnaround Document (APTAD)," will be created for any cases opened through the automated process.

B. Applications Denied through the Automated Process

Some applications transmitted to the State from SSA for MSP benefits will be denied through the automated process. Applications denied using the automated process will include individuals who are:

- FPL; or reported on the SSA file as having income in excess of 135% of the
- denied by SSA as not in receipt of Medicare.

These applicants will be sent a denial notice by the State through CNS which will include contact information for the appropriate local district. If the applicant is denied MSP benefits for excess income, the denial notice will indicate the net income derived from the percentage of the Federal Poverty Level for the applicant as reported on the SSA file, and compare this amount to the highest income level for the Medicaid Savings Program, which is 135% of the FPL. The notice will also state that the applicant may request a Fair Hearing if he or she disagrees with the decision made by the State. (Refer to Section V. for information about Fair Hearings.)

IV. REQUIRED ACTION

Each local district will receive a daily Benefits Issuance and Control System (BICS) report, WINR5531, of MSP applications received from SSA. The report will include name, Client Identification Number (CIN) and case number for each application, date of application for LIS, and will indicate whether the application was automatically accepted, denied, or exceptioned for manual review by the district. An MSP application will not be registered if the applicant already has an active Medicaid and/or MSP case. (See Section IV.A.1.)

Case numbers assigned through the automated process will contain a unique identifier to distinguish them from cases derived through other sources and will begin with the letters “LI”. The case number format will be LIYYDDD999, where YY is year, DDD is Julian day, and 999 is sequence number. The “Office” will be identified as “LIS”, the “Unit” will be “MSP”, and the “Worker” will be “NYSSA”. The application will remain in “Pend” status for three business days. While the application is in “Pend” status, the LDSS may change the case number, office, unit, or worker but cannot cancel the case.

A. Applications Exceptioned

Some applications transmitted to the State from SSA will require manual review and determination of benefits by the local district. These applications and the reason for the exception will appear on the BICS WINR5531 report sent to each local district. All exceptioned applications appearing on the WINR5531 report must be reviewed for MSP eligibility. The LDSS must send the appropriate MSP acceptance or a denial notice using current CNS notices once a determination of benefits is completed.

1. Types of Exceptioned Applications Requiring Manual Processing

a. Individuals already in receipt of MSP (MSPI Value present)

For individuals who are already in receipt of MSP benefits, no action is required to be taken.

b. Individuals already in receipt of Medicaid without MSP

For individuals who are in receipt of Medicaid, but not in receipt of MSP benefits, districts must review the information in the current case record to ascertain whether the applicant should have been determined eligible for MSP. If found eligible, the district must accrete the individual to the Medicare Savings Program and send the appropriate notice. (Refer to Section IV.A.2. of this ADM.) If after reviewing the case, the individual is determined to be ineligible for MSP, the LDSS must deny MSP benefits to the individual and send the appropriate notice. The current Medicaid case would remain unchanged.

Some individuals who are in receipt of Medicaid may be using their Medicare premium as a deduction from income in order to qualify for full Medicaid or to reduce their spenddown obligation under the Excess Income Program. In either case, the LDSS must offer these individuals the choice to either participate in the Medicare Savings Program or to continue using their Medicare premium to qualify for Medicaid. This choice must be offered even if the individual has previously stated his or her selection. Attached is OHIP-0037, “Option to Receive Medicare Savings Program (MSP) Benefit” (Attachment II), that must be sent to these individuals allowing them to indicate their choice. This form should be sent with OHIP-0026, “Explanation of the Excess Income Program” (Attachment III).

If the individual does not return the completed form, the Medicaid case would remain unchanged and no further action would be required. If the recipient returns the form and requests payment of Part B premiums, the district must recalculate Medicaid eligibility, accrete the individual to the Medicare Savings Program and send the appropriate MSP acceptance notice and change in eligibility notice. (Refer to Section IV.A.2. of this ADM.)

c. Individuals with an “M” suffix on the Health Insurance Claim Number (HICN)

Most individuals who are eligible for Medicare Part B are also eligible for premium free Part A coverage. However, some individuals who are eligible for Medicare Part B do not have credit for sufficient work quarters to qualify for free Medicare Part A. An “M” suffix on the HICN indicates an individual does not have sufficient work credit for premium free Medicare Part A.

Some individuals are eligible for Medicaid payment of their Medicare Part A premium through the Part A Buy-In program. Refer to GIS 04 MA/013 for more information on Medicare Part A Buy-In procedures.

If an active case exists for the individual, LDSS must review the file to determine whether the applicant is eligible for the Part A Buy-In program. If the individual qualifies for payment of their Medicare Part A premium through the Part A Buy-In program, a QMB case should be opened and an acceptance notice sent using Reason Code X54, Accept Medicare Buy-In Program (QMB). If the applicant is not eligible for payment of their Part A premium, the application for MSP benefits should be denied and a notice sent using Reason Code X52, Deny Medicare Buy-In Program (QMB). The current Medicaid case would remain unchanged.

If this is a new applicant, LDSS staff must mail the "Medicare Savings Program Request for Information" form (Attachment I) with the "Request for Information Cover Letter" (Attachment IV) to the individual. If the applicant does not return the completed form, LDSS must send manual denial notice OHIP-0036, "Notice of Denial for Medicare Savings Program (Application Received from SSA)."

d. Applications with blank income fields on the SSA file

For new applicants whose income information on the SSA file is blank (income field is not completed), the LDSS must obtain from the applicant the information necessary to process the application. The LDSS must send DOH-4496, "Medicare Savings Program Request for Information" (Attachment I) with the "Request for Information Cover Letter" (Attachment IV) to obtain income information and verification necessary to process the application. Once the district obtains the necessary income information, a MBL budget must be created. An acceptance or a denial notice must be sent using current CNS notices once a determination of benefits is completed. Applicants who do not return the form must be sent manual denial notice OHIP-0036, "Notice of Denial for Medicare Savings Program (Application Received from SSA)."

Applicants who indicate they have no income ($0 reported on the SSA file) will not appear on the daily BICS WINR5531 report. These applications will be processed automatically since income information was provided by the individual and verified by SSA.

2. Manual eMedNY Implications

The LDSS is responsible for processing all MSP applications accepted following manual review and for any requests for retroactive coverage. The LDSS is also responsible for the manual review and determination of benefits for applications appearing as exceptioned on the WINR5531 report.

a. The LDSS must enter all necessary information in the eMedNY Buy-In screens, including the appropriate MSP code used to indicate the category of MSP awarded: QMB, SLIMB or QI.

b. For all MSP categories, the "Begin Dates" for Medicare Part A and Part B coverage are to be entered as the first day of the month of application for LIS, unless the district has obtained more accurate information from the applicant, or if the applicant has been determined eligible for retroactive payment of premiums.

c. For individuals found eligible for SLIMB and QI, the MSP Buy-In "Begin Date" is equal to the first day of the month of application to SSA for LIS, unless the applicant is determined eligible for retroactive payment of premiums. For those found eligible for QMB, the MSP Buy-In "Begin Date" is equal to the first day of the month following the month of application for LIS. A Common Benefit Identification Card must be issued to all QMB recipients.

d. For individuals found eligible for QMB, a card code of "N" must be entered so these recipients will receive a non-photo CBIC. For those determined to be eligible for SLIMB and QI, a card code of "X" must be entered so a CBIC is not issued.

The application date for new MSP applications sent to the State by SSA is equal to the date the individual applied for LIS benefits at SSA. This date is reflected on screen 1 of WMS as the "Application Date." The date an eligibility determination is performed is reflected on screen 1 of WMS as the "Transaction Date."

Note: The LDSS must determine eligibility for all applications on the Exception Report promptly, generally within 45 days of the date that the district receives the information from the State. Under certain circumstances, additional time for determination of eligibility may be required, such as in the case of a delay on the part of the applicant, or in the case of an administrative or other emergency that could not be controlled by the district.

B. Cases Incorrectly Assigned to a District

If the LDSS identifies a case opened through the automated process that was assigned to the district incorrectly, the district must transfer the case to the appropriate district in accordance with current protocols. In this situation, the assigned district must contact the correct district to obtain its agreement to transfer the case and coordinate closing the incorrectly assigned case with the opening of a new case in the correct district.

This process must take place in a manner that allows coverage to continue without interruption, and the manual notice OHIP-0014, "Notice of Transition of Your Medicaid/Family Health Plus/Family Health Plus-Premium Assistance Program/Family Planning Benefit Program and/or Medicare Savings Program Coverage (County A)," must

be sent to the recipient (Attachment V). If the assigned district does not obtain agreement from the other district to open the case, the assigned district must maintain the opened case until the district of fiscal responsibility is determined through a Fair Hearing. Once a case is successfully transferred to the correct district, the new district must send manual notice OHIP-0015, "Notice of Transition of Your Medicaid/Family Health Plus/Family Health Plus-Premium Assistance Program/Family Planning Benefit Program and/or Medicare Savings Program Coverage (County B)" (Attachment VI) to the recipient.

C. Duplicate Cases

There may be instances when the automated process does not recognize an existing CIN in WMS for an individual whose application appears on the SSA file. A new case may be registered with a new CIN for an individual.

1. Original Case is Active

In the event that the LDSS discovers that a duplicate case/CIN was opened through the automated process, the LDSS must consolidate cases/CINs.

- Close the newly created case.
- Close the Medicare Buy-In span established by the automated process.
- Consolidate the CINs assigned to the individual.
- Retain the CIN of the original case.
- Delete the newly created CIN.

A new manual notice, OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error" (Attachment VII) informs the recipient that a duplicate case was opened in error through the automated process. The notice also advises whether the individual will receive MSP benefits under the original Client Identification Number. In addition, districts must take the following actions, depending upon the benefits the individual is currently receiving.

a. For active cases with MSP only or active Medicaid with MSP, and a duplicate case is opened for MSP:

- Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error" (Attachment VII). Enter the effective date, name and CIN for the discontinued case.
  - o Check the first box indicating the CIN under which the individual will continue to receive MSP benefits. Enter the CIN for the retained case.
- If a CBIC was issued for the duplicate case, the bottom section of the notice must be completed.
  - o If the duplicate case was for QMB, check the box saying the discontinued CBIC will no longer work, and enter the CIN found on that card.

- If the recipient was issued a card on the original case, check the box instructing the recipient to keep the original card, and enter the CIN for that card.

b. For active Medicaid only cases (no spenddown) without MSP benefits, and a duplicate case is opened for MSP, review the existing case for MSP eligibility.

- If MSP eligible:
  - Enter the MSP code in WMS under the retained CIN.
  - Create a Buy-In span in eMedNY for MSP under the retained case.
  - Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error." Enter the effective date, name and CIN for the discontinued case.
  - The recipient will receive MSP benefits under the retained CIN.
    - Check the first box indicating the CIN under which the individual will receive benefits. Enter the CIN for the retained case.
  - If a CBIC was issued for the duplicate case, the bottom section of the notice must be completed.
    - If the duplicate case is for QMB, check the box saying the discontinued card will no longer work, and enter the CIN found on that card.
    - If the recipient was issued a card on the original case, check the box instructing the individual to keep the original benefit card, and enter the CIN for that card.

- If not MSP eligible:
  - Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error." Enter the effective date, name and CIN for the discontinued case.
    - Check the second box stating the individual will continue to receive Medicaid under the retained CIN and enter the CIN for that case.
    - Check the first indented box and enter the net income and MSP limit of 135% FPL.
  - If a CBIC was issued for the duplicate case, the bottom section of the notice must be completed.
    - If the duplicate case was for QMB, check the box saying the discontinued CIBC will no longer work, and enter the CIN found on that card.
    - If the recipient was issued a card on the original case, check the box instructing the individual to keep the original benefit card, and enter the CIN for that card.
  - The original Medicaid case will remain unchanged.

c. For active Medicaid cases having a spenddown:

- Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error." Enter the effective date, name and CIN for the discontinued case.

- Check the second box stating the individual will continue to receive Medicaid under the retained CIN and enter the CIN for that case.
- Check the second indented box indicating the option to choose to participate in the Excess Income Program or MSP.

- If a CBIC was issued for the duplicate case, the bottom section of the notice must be completed.
  - If the duplicate case was for QMB, check the box saying the discontinued CBIC will no longer work, and enter the CIN found on that card.
  - If the client was issued a CBIC on the original case, check the box instructing them to keep the original CBIC, and enter the CIN for that card.
- Send OHIP-0037, "Option to Receive Medicare Savings Program (MSP) Benefit."
- Send OHIP-0026, "Explanation of the Excess Income Program."
- If OHIP-0037 is returned, make all necessary adjustments to the case and send the appropriate notice to the individual.
- If the individual does **not** return OHIP-0037, the original (retained) Medicaid case will remain unchanged.

d. For active Medicaid only cases in WMS, and the MSP application on the SSA file is denied using a duplicate CIN:

- Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error."
- The recipient will continue to receive Medicaid under the retained CIN.
  - Check the second box stating the individual will continue to receive Medicaid under the retained CIN and enter the CIN for that case.

e. For active cases with MSP only or active Medicaid with MSP, and the MSP application on the SSA file is denied using a duplicate CIN:

- The recipient will continue to receive benefits under the retained CIN.
- Check the first box indicating the CIN under which the individual will continue to receive MSP benefits. Enter the CIN for the retained case.
- If the individual is also in receipt of Medicaid coverage, check the box indicating the CIN under which the individual will continue to receive Medicaid coverage.

2. Original Case is Closed

The LDSS must consolidate cases/CINs when it discovers that a duplicate case/CIN was created through the automated process and the original case is closed.

- Consolidate the CINs assigned to the individual.
- Retain the CIN of the original case.
- Delete the newly created CIN.

a. For closed cases and the MSP application on the SSA file is denied using a duplicate CIN, no further actions are required to be taken.

b. For closed cases and the MSP application on the SSA file is opened using a duplicate CIN, districts must also take the following actions:

- Reopen the original case.
- Transfer the MSP data to the original case in WMS and eMedNY.
- Enter the MSP indicator on Screen 3.
- Create a Buy-In transaction in eMedNY.
- Send OHIP-0051, "Notice of Medicare Savings Program Case Opened in Error." Enter the effective date, name and CIN for the discontinued case.
- The recipient will receive MSP benefits under the retained CIN.
  - Check the first box indicating the CIN under which the individual will receive benefits. Enter CIN for the retained case.
- If a CBIC was issued with the duplicate CIN, the bottom section of the notice must be completed.
  - If the duplicate case was for QMB, check the box saying the discontinued CBIC will no longer work, and enter the CIN found on that card.
  - If the new case is for QMB, the client will be issued a CBIC with their original CIN. Check the box instructing them to keep that CBIC, and enter the CIN for that card.

V. FAIR HEARINGS

The LDSS is responsible for Fair Hearings requested on any MSP application received and processed through the SSA file. If an individual requests a Fair Hearing, the district must obtain a copy of the notice sent by CNS. The notices will be available via WEBCOINS/COLD through CentraPort. Since MBL budgets are not produced for cases accepted or denied through the automated process, the district must obtain the information provided on the SSA file. This information may be obtained by contacting the NYSDOH Third Party Liability (TPL) Unit in the Division of Coverage and Enrollment and requesting a "MIPPA Report" for the applicant.

The TPL Unit will provide the district with the application information that was received by SSA and a written affidavit explaining the automated MSP enrollment process for use at the Fair Hearing. The Third Party Liability Unit may be contacted by calling (518)473-5330, or by email at jxm24@health.state.ny.us. Fair Hearing staff are aware of the State's automated procedure for processing these applications.

If a case is remanded to the district for follow-up with the applicant after the hearing, it is not necessary to require the individual to complete an MSP application. The district may ask for verification of the item(s) disputed in the hearing in order to redetermine MSP eligibility.

VI. NOTICE REQUIREMENTS

New Client Notice System (CNS) acceptance and denial notices have been developed to be used for the automated processing of MSP applications received from SSA.

The new acceptance notices include a copy of the DOH-4496, "Medicare Savings Program Request for Information," for applicants/recipients (A/Rs) to use if they wish to submit additional financial or demographic information not collected on the LIS application. The form also allows the A/R to request consideration for retroactive coverage. A/Rs are instructed to return completed forms to the local district office for processing. The LDSS must review and process these forms in a timely manner following established procedures. Returning the "Medicare Savings Program Request for Information" form is voluntary for cases that are opened through the automated process. Failure by the individual to return this form is not grounds for terminating MSP coverage.

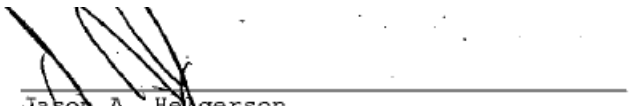
The following new notices and reason codes have been created for applications accepted and denied through the automated process:

Reason Code 892: Accept QMB from LIS Application
Reason Code 893: Accept SLIMB from LIS Application
Reason Code 894: Accept QI from LIS Application
Reason Code 848: Deny MSP from LIS Application Over Income
Reason Code 849: Deny MSP from LIS Application Not Medicare

Existing CNS or manual notices are to be used for cases manually reviewed by the district from the Exception Report.

VII. EFFECTIVE DATE

The effective date of this ADM is February 21, 2011.



Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Application Date: _____

Medicare Savings Program
Request for Information

(Please print clearly and do not write in dark shaded area)

APPLICANT	First Name	M.I.	Last Name			HOME PHONE
HOME ADDRESS Is this a Shelter? Yes __ No__	Street	Apt.	City	State	Zip Code	County
MAILING ADDRESS *(If different from above)*	Street/P.O. Box	Apt.	City	State	Zip Code	County

NAMES (*List your name first. Include aliases and maiden name*)

	First	M.I.	Last	Date Of Birth	Sex	Social Security Number	Race/Ethnic Code (Optional)
SELF							
SPOUSE							
CHILD*							

**If under 18 years of age. Attach extra sheet if necessary to list additional children.*

Race/Ethnic Affiliation Codes: (You may pick more than one.)
A- Asian **B –** Black or African American **H –** Hispanic or Latino **I -** Native American or Alaskan Native
W - White **P** – Native Hawaiian or other Pacific Islander **U -** Unknown

APPLICANT'S MEDICARE INFORMATION Medicare # _____(*From red and blue Medicare card*)

Do you have Medicare Part A? __Yes __No Effective Date _____

Do you have Medicare Part B? __Yes __No Effective Date _____

SPOUSE'S MEDICARE INFORMATION, if applying Medicare # _____(F*rom red and blue Medicare card*)

Does spouse have Medicare Part A? __Yes __No Effective Date _____

Does spouse have Medicare Part B? __Yes __No Effective Date _____

Would you like us to consider providing retroactive reimbursement of your Medicare premium? __Yes __No

Do you or your spouse pay any health insurance premiums other than Medicare? ___ Yes ___No Who? _____ Monthly Amount $_____

Do you or your spouse pay child/spousal support? ___ Yes ___No Who? _____ Monthly Amount $_____

Do you wish to apply for full Medicaid benefits? ___ Yes ___No (If you answer "Yes" to this question, we will send you an application for Medicaid benefits.)

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc. List amount received before any taxes or other deductions.

Names of Applicant, Spouse, or Child under 18 (*Attach an extra sheet if necessary*)	**Who Provides the Money?** (*Name/source of Income*)	**What Amount?**	**How Often?** (*weekly, two weeks, monthly*)

Do you want to receive notices in: __ **English Only** __ **Spanish and English**

By signing this form, I understand that each person listed will be enrolled in the appropriate program, if eligible. I have also read and understand the Terms, Rights and Responsibilities on the following page. I certify under penalty of perjury that everything on this application is the truth as best I know.

_____ _____
Signature of Applicant or Representative Date

_____ _____
Signature of Spouse Date

_____
Representative Address, Phone Number and Relationship

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program please sign on the following line.

I consent to withdraw my application _____ Date _____

DOCUMENTATION: You must send proof of income and proof of any health insurance premiums that you pay. Please review this list and submit the documents that you will need to provide in order for the Medicaid Program to determine if you are eligible for additional benefits. If you are requesting retroactive reimbursement of your Medicare premiums, you must send proof of income for the three month period before the "Application Date" listed in the upper right corner of this form.

- **Proof of income:** Paycheck stubs, letter from employer, income tax return, award letter for any unearned income benefit such as social security, unemployment, or veteran's benefit, or letter from renter, boarder or tenant.
- **Health Insurance premiums that you pay other than Medicare**: Letter from employer, premium statement, or pay stub.

To avoid a delay in processing, remember to sign and date this application in the space indicated above.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying for the Medicare Savings Program. **PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT.**

PENALTIES: I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid benefits or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Medicaid or if you conceal or fail to disclose facts that would effect the right of someone for whom you have applied to obtain or continue to receive Medicaid benefits; and such benefits must be used by the other person and not for yourself.

CHANGES: I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

SOCIAL SECURITY NUMBER (SSN): If you are applying for the Medicare Savings Program, you must report your SSN, unless you are a pregnant woman. The laws requiring this are: 18NYCRR Sections 351.2, 360-1.2, and 360-3.2(j)(3); 42USC 1320b-7. SSNs are used in many ways, both within the local social services districts and also between local social services districts and federal, state, and local agencies, both in New York and in other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if absent parents can get health insurance for applicants, to see if applicants can get child support and to see if applicants can get money or other help.

CERTIFICATION OF CITIZENSHIP & IMMIGRATION STATUS: I certify, under the penalty of perjury, by signing my name on this application, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the United States Citizenship and Immigration Services (USCIS) for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid program.

NON-DISCRIMINATION NOTICE: This application will be considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.

CERTIFICATION: In signing this application, I swear and affirm that the information I have given or will give to the Department of Social Services as a basis for Medicaid is correct. I also assign to the Department of Social Services any rights I have to pursue support from persons having legal responsibility for my support and to pursue other third-party resources. I understand that Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

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

<table>
<tr><td colspan="3">SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION:
x</td><td>DATE:</td><td colspan="4">EMPLOYED BY:</td></tr>
<tr><td colspan="4">Eligibility Determined By Worker: _____ (DATE)</td><td colspan="4">Eligibility Approved By: _____ (DATE)</td></tr>
<tr><td>CENTRAL/OFFICE</td><td>APPLICATION DATE</td><td>UNIT ID</td><td>WORKER ID</td><td>CASE TYPE</td><td colspan="2">CASE NO</td><td>REUSE IND.</td></tr>
<tr><td colspan="2">CASE NAME</td><td colspan="2">DISTRICT</td><td colspan="3">REGISTRY NO.</td><td>VER.</td></tr>
<tr><td colspan="4">Effective Date _____ MA Disp. Denial Withdrawal</td><td colspan="2">REASON CODE</td><td colspan="2">PROXY:
Yes No</td></tr>
</table>

Option to Receive Medicare Savings Program (MSP) Benefit

Date:

Dear Consumer:

You recently applied to the Social Security Administration for Extra Help with your Medicare Part D prescription drug coverage. At that time, you agreed to have your application sent to the New York State Medicaid office to apply for help with your Medicare costs.

This is to advise you that the New York State Medicaid Program has determined that you are eligible for the Medicare Savings Program. However, participation in the Medicare Savings Program may affect the benefits you are currently receiving. Please read the paragraph checked below.

- ☐ You are currently eligible for full Medicaid benefits as long as you continue to pay your Medicare Part B Premium. However, if you choose to join the Medicare Savings Program (MSP) and have your Medicare premium and other coinsurance payments paid by the Medicaid Program, you will only be eligible for Medicaid under the Medicaid Excess Income Program. Under the Medicaid Excess Income Program you can only receive Medicaid coverage in a month when paid or unpaid medical bills equal or exceed your monthly excess income amount of $_____. **You will have to provide proof that you have medical expenses each month at least equal to this amount before you can get Medicaid coverage for the remainder of the medical bills for that month.** See the enclosed form, "Explanation of the Excess Income Program," for information about that program.

- ☐ You are already enrolled in the Medicaid Excess Income Program. **If you choose to have the Medicare Savings Program pay your Medicare premium and possibly other coinsurance payments, your Medicaid monthly excess amount will increase from $_____ to $_____.** You will have to provide proof that you have medical expenses each month at least equal to this new amount before you can get Medicaid coverage for the remainder of the medical expenses for that month.

- ☐ You are already enrolled in the Medicaid Excess Income Program. You are also eligible to have your Medicare Part B premium paid through the Medicare Savings Program as a Qualified Individual (QI program). However, you may not receive both the QI program and the Medicaid Excess Income Program. You may only choose one. If you choose not to join the Medicare Savings Program, you will continue to be enrolled in the Medicaid Excess Income Program.

For many people, full Medicaid coverage through the Medicaid Excess Income Program is the more beneficial coverage. However, if you do not have a lot of medical bills each month that are not paid by Medicare, you may prefer to be enrolled in the Medicare Savings Program, which will pay your Medicare Part B premium every month that you remain eligible for the Medicare Savings Program.

NOTE: If you are currently receiving Food Stamps and you choose to join the Medicare Savings Program, your Food Stamp benefits may be reduced.

If you would like to join the Medicare Savings Program, print your name, sign and date the form, and return the form to the county address above by _____.

If you do not return this form by the date stated above, your Medicaid benefits will continue unchanged.

I understand the options available to me and I want to join the Medicare Savings Program.

_____

Print Name Date

_____

Sign Here

Explanation of the Excess Income Program

If your monthly income is over the Medicaid level, you may still get help with your medical bills. This letter explains how to do that. The amount your income is over the Medicaid level is called excess income. The Notice of Decision letter you received tells you the amount of your excess income. Once you have medical bills at least equal to your excess income (spenddown or surplus) which is like a deductible, Medicaid will pay your medical bills for the rest of the month.

How to get Medicaid through the Excess Income Program

First, you must be under age 21, age 65 or older, certified blind or certified disabled, pregnant or a parent of a child under age 21. This allows you to become eligible for Medicaid even though your monthly income is too high. You can spenddown to the Medicaid level in one of two ways:

1. ***Outpatient Care and Services (One Month Eligibility)***

   If you need outpatient care, in a hospital, clinic or doctor's office, prescription drugs or medical supplies, you may be able to get help with these bills. If you have medical bills that are equal to or more than your monthly excess income, you can get Medicaid outpatient services for one month. The Excess Income Program can provide outpatient coverage for one month at a time.

   First, you need to tell your local Department of Social Services that you want to be in the Excess Income Program. You must then bring in or send your medical bills to your local Department of Social Services when they at least equal your excess income amount. These bills can be paid or unpaid. You will need to do this each month you need outpatient care.

   You may be able to get long-term care services like adult day health care, personal care services and the Assisted Living Program. Your social services worker will be able to tell you if you are eligible for these services.

Or

2. ***Inpatient/Hospital Care and Services (Six Months Eligibility)***

   If you need hospital care or need help paying your hospital bills, you may be able to get Medicaid inpatient services, in addition to the outpatient care described above. You must have medical bills that are at least equal to your monthly excess income amount for six months. These bills can be paid or unpaid. They can also be for medical services other than hospital care.

   Once your medical bills at least equal your excess income amount for six months, you must bring or send these bills to your local Department of Social Services. You will then receive Medicaid for six months.

Pay-In Option If you do not have medical bills but you need medical care, there is another option called the Pay-In Program. You can pay your monthly excess income amount for any month to your local Department of Social Services. You should only do this if you need services in that month. Ask your social services worker about this option.

Once You Enroll in the Excess Income Program

- Each month you need Medicaid services, bring in, send, or fax (if available in your county) your medical bills to your local Department of Social Services. Only send these bills when they are equal to or more than the amount of your excess income.

- You should make doctors' appointments or fill prescriptions early in the month. This will help you meet your excess income amount faster. Once you reach your excess income amount, Medicaid will pay for covered services for the rest of the month.

Bills You Can Use Toward Your Excess Income

- You may use bills from a doctor or other medical provider who does not take Medicaid.

  Important Note: *Once you have enough bills to meet your excess income for any month, Medicaid will only pay medical bills in that month from a doctor, pharmacist, or other provider who is in the New York State Medicaid program. You need to see if your doctor or other medical provider is enrolled in Medicaid so your bills can be paid. You cannot use bills from a non-Medicaid provider until the next month when you need to meet your excess income again.*

- You can use any part of a bill that Medicare or private insurance does not pay. You cannot use a bill that Medicare or private insurance will pay in full.

- Bills may be for medical care given to you, your spouse, or your children who are under 21 years old. If you provide medical support for a child not living with you, you may be able to use the child's bills. Medical bills for your parent(s) may also be used toward meeting your monthly excess if you are under 21 and live with your parent(s).

- You can use unpaid medical bills from prior months to meet your current monthly excess income. Once you use a bill to meet your excess income, you cannot use it again.

You can also use the following bills to meet your excess income amount:

- The cost of transportation to get to and from medical appointments (in most cases);

- Medical bills or payments made to therapists, nurses, personal care attendants and home health aides (as ordered by a doctor);

- Prescription drug bills;

- Payments made for surgical supplies, medical equipment, prosthetic devices, hearing aids and eyeglasses (as ordered by a doctor); and

- Any bills paid by public programs of the State or county like the Elderly Pharmaceutical Insurance Program (EPIC) or the AIDS Drug Assistance Program (ADAP), and your copayments.

In addition, you can use medical bills that the Medicaid program does not cover like:

- Chiropractor services and other non-covered medical services;

- Co-payments you are charged when you receive certain Medicaid services;

- Some over-the-counter drugs and medical supplies such as bandages. You can use these to meet your spenddown if your doctor has ordered them. Bills for cosmetics and other non-medical items are not allowed; and

- Any out-of-pocket costs associated with the Medicare Prescription Drug Program such as premiums, co-payments and deductibles.

If you have questions, please contact your county's Department of Social Services.
For more information go to http://nyhealth.gov/health_care/medicaid/

Regulations require that you immediately notify your county's Department of Social Services of any changes in need, income, resources (if you are age 65 or older, certified blind or certified disabled), living arrangements and address.

Request for Information Cover Letter

Date:

Dear Consumer:

You recently applied to the Social Security Administration for Extra Help with your Medicare Part D prescription drug coverage. At that time, you agreed to have your application sent to the New York State Medicaid office to apply for help with your Medicare costs through the Medicare Savings Program.

In order for us to determine if you are eligible for this benefit, we need some additional information. Please complete the attached "Request for Information" form and return it to us with the following documents to the address listed above by: _____.

- A photocopy of the front and back of your Medicare card (the red, white and blue card).
- Proof of income, such as paychecks stubs, a letter from employer, income tax return, award letter for any unearned income benefit such as social security, unemployment, or veteran's benefit, or letter from renter, boarder or tenant.
- Proof of any other health insurance premium that you pay other than Medicare, such as a letter from employer, premium statement or pay stub.
- If you are not a U. S. citizen, you must provide documents indicating your current immigration status.

If we do not receive the requested information you will be unable to receive benefits through the Medicare Savings Program and we will send you a notice informing you that you are not eligible for the Medicare Savings Program.

You may use the enclosed "Request for Information" form to ask to be considered for full Medicaid benefits. If you check "Yes" to this question on the form, we will send you a separate application packet to apply for Medicaid benefits.

If you need help with this form, you may contact the Medicaid office listed above or contact the Health Insurance Information Counseling & Assistance Program (HIICAP) at 1-800-701-0501. TTY users should call 1-877-486-2048.

Enclosure

NOTICE OF TRANSITION OF YOUR MEDICAID/FAMILY HEALTH PLUS/FAMILY HEALTH PLUS-PREMIUM ASSISTANCE PROGRAM/FAMILY PLANNING BENEFIT PROGRAM AND/OR MEDICARE SAVINGS PROGRAM COVERAGE (County A)

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

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

This is to inform you that we will continue Medicaid/Family Health Plus/Family Health Plus-Premium Assistance Program/Family Planning Benefit Program and/or Medicare Savings Program coverage for name(s) _____ _____ until _____.

Because you have informed us of your move, your case will be transferred to your new district of residence effective _____. You will receive more information about your coverage from your new district.

Important Information for Family Health Plus Enrollees

You will continue to be a member of your current Family Health Plus plan until the effective date above. You will be enrolled in the same plan if this plan is offered in your new county. If your current plan is not available in your new county, you will be assigned a new health plan. If you have any questions about your health plan enrollment, call the managed care unit in your new local social services district.

Important Information for Family Health Plus-Premium Assistance Program Enrollees

Individuals who are enrolled in cost effective Employer Sponsored Health Insurance will continue to be eligible for the Family Health Plus-Premium Assistance Program until the effective date above.

Important Information for Medicaid Managed Care Enrollees

You will be enrolled in the same Managed Care plan if your current plan is offered in your new county. If your current plan is not offered in your new county, you will need to use your New York State Benefit Identification Card to access medical care from a Medicaid provider after the effective date above.
If you are required to enroll in a new Medicaid Managed Care plan in your new county, you will be sent information about available plan selections. If you have questions about your health plan enrollment, call the managed care unit in your new local social services district.

Excess Income (Spenddown) Cases

For individuals whose income is over the allowable Medicaid income limit and who participate in the Excess Income Program, beginning _____, you will need to provide proof of paid or unpaid medical expenses to the Medicaid office in your new county. You may also pay your excess income amount to your new county.

Important Information for Family Planning Benefit Program Enrollees

Your enrollment in the Family Planning Benefit Program will continue until the effective date above.

Important Information for Medicare Savings Program Enrollees

Your enrollment in the Medicare Savings Program will continue until the effective date above.

This decision is based on Regulations 18 NYCRR 351.2(g)(1), 360-7.7 and 360-4.8(b) and Sections 364-j and 369-ee of the Social Services Law.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

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

NOTICE OF TRANSFER OF YOUR MEDICAID

CONFERENCE AND FAIR HEARING INFORMATION

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

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

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

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

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

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

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

_____

_____

Print Name: _____ Case Number: _____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

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

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

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

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

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

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

ATTENTION: Children under 19 years of age who are not eligible for Medicaid or other health insurance may be eligible for the Child Health Plus Insurance Plan (CHPlus). The plan provides health care insurance for children. Call 1-800-698-4543 for information.

NOTICE OF TRANSITION OF YOUR MEDICAID/FAMILY HEALTH PLUS/FAMILY HEALTH PLUS-PREMIUM ASSISTANCE PROGRAM/FAMILY PLANNING BENEFIT PROGRAM AND/OR MEDICARE SAVINGS PROGRAM (County B)

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

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

A Medicaid/Family Health Plus/Family Health Plus-Premium Assistance Program/Family Planning Benefit Program and/or Medicare Savings Program case will be opened for the following names(s)_____ _____ effective _____.

This is because you are now a resident of _____.

Important Information for Family Health Plus Enrollees

You will be enrolled in the same Family Health Plus (FHP) plan if it is offered in this county. FHP enrollees whose current plan is not available in this county will be assigned a new plan. You will be notified about your new plan. You will be able to change plans under certain circumstances. All FHP enrollees will receive a new member packet from your new plan. If you have any questions about your health plan enrollment, call the managed care unit at the general phone number listed above.

Important Information for Family Health Plus-Premium Assistance Program Enrollees

The Family Health Plus-Premium Assistance Program will continue to make premium payments for your cost effective Employer Sponsored Health Insurance.

Important Information for Medicaid Managed Care Enrollees

You will be enrolled in the same Managed Care plan if it is offered in this county. Medicaid Managed Care enrollees whose current plan is not offered in your new county will need to use your New York State Benefit Identification Card to access medical services from Medicaid providers after the effective date above. If you are required to enroll in a Managed Care plan in this county, you will be sent information about available plan selections. If you have questions about your health plan enrollment, or want information about what plans you can join in this county, call the managed care unit at the general telephone number listed above. Medicaid Managed Care enrollees will receive a new member packet from your plan.

Excess Income (Spenddown) Cases

For individuals whose income is over the allowable Medicaid income limit and who participate in the Excess Income Program, beginning _____ you will need to provide proof of paid or unpaid medical expenses to this agency in order to be eligible for payment of any additional covered outpatient expenses. You may also pay your excess income amount to this agency for any month you need outpatient coverage.

Important Information for Family Planning Benefit Program Enrollees

The Family Planning Benefit Program will continue to cover services that may help prevent or reduce unwanted pregnancies.

Important Information for Medicare Savings Program Enrollees

The Medicaid Program will continue to pay your Medicare premiums. If Medicaid was also paying your co-insurance and deductibles, we will continue to pay these costs.

This decision is based on Regulation 18 NYCRR 351.2(g)(1), 360-7.7 and 360-4.8(b) and Sections 364-j and 369-ee of the Social Services Law.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

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

NOTICE OF TRANSFER OF YOUR MEDICAID

CONFERENCE AND FAIR HEARING INFORMATION

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

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

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

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

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

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

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

_____

_____

Print Name: _____ Case Number: _____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

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

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

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

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

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

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

ATTENTION: Children under 19 years of age who are not eligible for Medicaid or other health insurance may be eligible for the Child Health Plus Insurance Plan (CHPlus). The plan provides health care insurance for children. Call 1-800-698-4543 for information.

NOTICE OF MEDICARE SAVINGS PROGRAM CASE OPENED IN ERROR

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

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

You recently applied to the Social Security Administration for Extra Help with your Medicare Part D prescription drug coverage. At that time, you agreed to have your application sent to the New York State Medicaid office to apply for help with your Medicare costs through the Medicare Savings Program.

At the time your application was received, a duplicate case was opened for you in error. This notice is to inform you that the duplicate case is being closed.

We will **DISCONTINUE** Medicare Savings Program benefits effective _____ for _____ under Client Identification Number (CIN) _____.

- ☐ You will continue to receive Medicare Savings Program benefits under CIN _____.
- ☐ You will continue to receive Medicaid unchanged under CIN _____.
  - ☐ This is because your net income (gross income less Medicaid deductions) of $_____ is over the Medicare Savings Program income limit of $_____.
  - ☐ This is because you have the option to participate in the Excess Income Program or the Medicare Savings Program. See the enclosed OHIP-0037, Option to Receive Medicare Savings Program (MSP) Benefit.

(Check if applicable)

- ☐ You may have in your possession more than one Benefit Identification Card. Your original card is the one you should use to obtain benefits. On your card(s), you will find a Client Identification Number.
  - ☐ You should destroy the card with Client Identification Number _____ if you received one. It will no longer work.
  - ☐ You should keep the card with Client Identification Number _____. This is the card that you will use to obtain health benefits.

The law(s) and/or regulation(s) which allow us to do this are Regulation 18 NYCRR 351.9 of the Social Services Law.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

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

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

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

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

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

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

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

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

_____

_____

_____

Print Name: _____ Case Number:_____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

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

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

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

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

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

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

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

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

ATTENTION: Children under 19 years of age who are not eligible for Medicaid or other health insurance may be eligible for the Child Health Plus Insurance Plan. The plan provides health care insurance for children. Call 1-800-698-4543 for information.