NEW YORK
state department of
HEALTH

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Commissioner

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 11 OHIP/ADM-9

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: October 18, 2011

SUBJECT: Automated Medicaid Renewal for Individuals with Fixed Incomes in the Aged, Blind and Disabled Category

SUGGESTED DISTRIBUTION:
Medicaid Staff
Fair Hearing Staff
Staff Development Coordinators

CONTACT PERSON:
Local District Liaison:
Upstate – (518)474-8887
New York City – (212)417-4500

ATTACHMENTS:
Attachment I - Upstate CNS Notice 796, Administrative Renewal for Aged, Blind and Disabled (System-Generated)

Attachment II - NYC CNS Notice 415, Administrative Renewal for Aged, Blind and Disabled (System-Generated)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		360-2.2(e) 360-6.2	366-a 366-a(2)	MRG Pgs. 481-485.1	94 LCM-84

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 the implementation of administrative, automated renewals for recipients in the Aged, Blind and Disabled category of Medicaid who receive fixed income from the Social Security Administration (SSA).

II. BACKGROUND

In an effort to lower costs and improve quality in the Medicaid program, the Medicaid Redesign Team (MRT) evaluated ideas presented by stakeholders and State staff. The MRT proposal to automate renewals for Aged, Blind and Disabled Medicaid recipients with fixed incomes was chosen for implementation. Currently, Medicaid recipients complete a mail renewal form once a year in order to continue to receive health care coverage. This is true even if the only income is fixed income (e.g., Social Security benefits) with known cost of living increases and when resources are well below the Medicaid resource level ($13,800 for an individual, $20,100 for a couple). Under administrative renewals, for Supplemental Security Income-Related (SSI-Related) single individual and couple households with fixed incomes where resources are less than 85% of the Medicaid resource limit at application or last renewal, whichever is later, the State will automate renewal of the case for Medicaid coverage. The individual/couple will not be required to mail in a renewal form in order to maintain their health care coverage.

III. PROGRAM IMPLICATIONS

Beginning in January 2012, the first upstate cases will be selected for automated renewal. Selected cases will have an Authorization “To” date of 3/31/12. For New York City (NYC), automated renewal selection will begin in December 2011, for cases with the same Authorization “To” date. The first weekend of each month, cases that meet specific criteria from the Welfare Management System (WMS), Medicaid Budget Logic (MBL) and Resource File Integration (RFI) will be selected for automated renewal. Any case not selected will be subject to renewal by the local district following the existing renewal process. Cases that will not be selected include cases: for the Medicare Savings Program (MSP) only; for nursing facility services; with excess income; and with a payline dated past the last day of the month in which the selection occurs. Cases selected are those composed of an individual or a married couple, who are eighteen years of age or older, with an Individual Categorical Code (ICC) of Aged (10), Blind (11) or Disabled (12), a Budget Type of 04 (SSI-Related), Social Security income as the only source of income, and resources that are at or below 85% of the applicable Medicaid resource limit.

The 85% figure was chosen to ensure that cases with resources close to the applicable Medicaid resource level receive a mail renewal. These cases will remain in the current manual renewal process. Resources and income contained in the MBL budget will be matched in an automated interface process with RFI. The process will match the information on the renewal file to the "hits" on the RFI database. Cases with RFI information that does not meet certain criteria will not be renewed by the automated process. Additionally, cases that will not be selected for automated renewal include any case with: a non-citizen or non-qualified alien; an Expanded Eligibility Code (EEC); a recipient who is turning 65 years old; or a case scheduled for a fair hearing.

Upstate cases that have an entry in the Cooperative Case field on screen 1 of WMS will not be selected for automated renewal. In order for a case to auto-renew this field must be blank; therefore, the field may no longer be used as a notes field. This field must be reserved for case numbers only.

The same weekend that a case meets all selection criteria from WMS, MBL and RFI, the system will update WMS and MBL with the appropriate transaction code (upstate only), a new reason code and new authorization and coverage periods that extend out one year from the current end date (see the Systems section of this ADM for upstate and NYC codes). An authorization number (9xxxxABD for upstate cases) will be generated for each case and an upstate LDSS 3209 Authorization Change or a NYC LDSS 3517 Turnaround Document (TAD) will be available for the district worker. For upstate districts, these cases will be batched on the Monday night following the first weekend of the month. For cases selected in NYC, the automated renewal transaction will be pended until one month prior to the expiration month. Upstate districts can identify the automated renewal cases on WMS by data in the Office, Unit and Worker fields. These fields will be set to ABD, RECRT and NYDOH, respectively and a report will be available through BICS (see section III. A., Reports). For New York City (NYC), the Originating ID will be set to ART (Auto Recert Transaction).

Because selected cases have income only from SSA benefits, MBL budgets will have been updated at the time of Mass Re-Budgeting and the effect of any changes in Social Security income will have already been addressed. At the time of automated renewal, the budgets for the selected cases will be automatically updated with a transaction code (upstate only) and the effective dates changed to match the new Authorization "From" date and Authorization "To" date. The current budget version number will be increased by one (1) and a new store date entered to reflect an updated budget. For upstate districts the automated renewal budgets are differentiated by the Office code of ABD, the Unit code of RECRT and the Worker code of NYDOH. For NYC the Originating ID will be changed to ART.

A system-generated notice will be sent to recipients whose case is auto-renewed (see Attachment I-Upstate and Attachment II-NYC and the Systems section for further information). The notice informs the recipient that Medicaid coverage is continued unchanged and that the recipient is responsible to report any changes in income, resources, health insurance, etc. to the district. The recipient should only respond if there is a change that needs reporting. If the local district worker receives any reported changes, the appropriate action(s) must be taken to update the Medicaid case.

Districts with an SSI-Related Re-Authorization waiver will be able to continue to extend authorizations for an additional 12 months on a case that is not selected for auto-renewal, as long as the case fits the criteria in the district's approved waiver (see 94 LCM-84, "Relief to Social Service Districts in the Reauthorization Review Process for SSI-Related Medical Assistance Cases").

A. Reports

1. Upstate Districts

After the automated renewal process occurs, WMS will produce a monthly report, WINR4009 "Automated Renewal Disposition Report." This report is sorted so that cases failing the automated renewal process are listed first and the cases successfully renewed are listed last. Cases that have a transaction that is pending during the automated renewal run will show as a failed update on this report. Failed updates will require worker action (see the Required Action section).

2. New York City

Cases that fail to update in the automated renewal process in New York City will be listed on the Daily Error Report (WINR0125) and usual procedures must be followed to correct the error (see the Required Action section for further instructions).

Auto-renewal will be expanded in the future to include MSP-only recipients, and Aged, Blind and Disabled recipients with excess income. In order to prepare for the inclusion of these cases in the auto-renewal process, certain steps will be taken at Mass Re-Budgeting (MRB), beginning with MRB in the fall of 2011.

B. Mass Re-Budgeting

1. Upstate Districts

At Mass Re-Budgeting (MRB), if worker action is required on a case, the case must be excluded from automated renewal until the worker completes the necessary action. For these cases, a new indicator field (ABD Renewal Indicator) has been created on screen 1 in WMS that will be filled at MRB with a system-generated code 1-Case Excluded from Automated Renewal. This code will be deleted when the worker enters a subsequent 06 (renewal), 07 or 08 (closing) transaction.

The new ABD Renewal Indicator code 1 is system-generated when a case:

- is exceptioned from MRB;
- changes from no excess income to excess income;
- has a decrease in excess income; or
- has a change in categorical eligibility for the Medicare Savings Program (MSP), e.g., a change from Qualified Medicare Beneficiary (QMB) to Specified Low Income Medicare Beneficiary (SLIMB).

For these cases, the current mail renewal process will be followed. System edits will prevent a worker from entering a 1 in this WMS field.

2. New York City

At MRB in New York City, when a case changes from no excess income to excess income or there is a change in categorical eligibility for the MSP program (see the example in the preceding section), the case will be exceptioned out of the automated renewal process and will receive a mailed renewal.

Note: A separate GIS will be issued to further explain changes to MRB.

IV. REQUIRED ACTION

The LDSS remain responsible for processing any changes reported by recipients whose case has been automatically renewed. The Administrative Renewal for the Aged, Blind and Disabled Notice (reason code 796 upstate and 415 for NYC) contains a more comprehensive list of changes for a recipient to report than a typical CNS notice. A change in income, resources or health insurance premiums will require an updated budget, while other changes, such as name, address, phone number, etc., will only require an update in WMS. The worker must take appropriate action based on the type of change reported.

A. Upstate Districts Failed Updates

Cases listed on the WINR4009 “Automated Renewal Disposition Report” as a failed update will require the district worker to make corrections. For cases with a pending transaction (reported as a failed update), the worker must wait for the transaction to complete. Once the reason for the failed update is addressed, the case may not be returned to the automated renewal process. The worker manually renews Medicaid coverage by updating the budget’s effective dates and storing the budget. WMS is updated with an 06 (renewal) transaction code, the reason code C29 (Administrative Renewal for Aged, Blind, Disabled-Worker–Manual) and the authorization and coverage dates are updated to periods that extend out one year from the current end date.

B. New York City Failed Updates

Cases selected for automated renewal that error are listed on the WINR0125 “Daily Error Report.” When the error is corrected through the Undercare Error Correction Subsystem, the case will continue through the automated renewal process.

If the worker elects to overlay the automated renewal error transaction, the worker will:

- enter the new budget version from auto-renewal;
- enter AC in the MA status field;
- enter reason code H99-Administrative Renewal for Aged, Blind, and Disabled (Worker-Manual);
- enter the new Authorization "From" date, and "To" date that extends out one year from the current end date;
- enter the RVI code; and
- enter the MA Recert Date.

Cases with a pending transaction in NYC at the time of automated renewal will be allowed to complete the pending transaction before the automated renewal is processed.

For both upstate districts and NYC, workers follow usual procedures to process cases that error out and require further information from the recipient. When the information is received and corrections are made, the worker follows the procedure in the above section IV. A. or B., as appropriate, in order to renew the case.

V. SYSTEMS IMPLICATIONS

A. WMS

1. Upstate Districts

All cases automatically renewed will have system-generated:

- transaction code of 06 (renewal);
- reason code 796-Administrative Renewal for Aged, Blind and Disabled;
- new authorization and coverage periods that extend out one year from the current end date;
- authorization number (9xxxxABD);
- Transaction Office - ABD;
- Unit - RECRT; and
- Worker ID - NYDOH.

2. New York City

All cases automatically renewed will have system-generated:

- reason code 415-Administrative Renewal for Aged, Blind and Disabled;
- new authorization and coverage periods that extend out one year from the current end date;
- authorization number; and
- Originating ID will be changed to ART.

B. MBL

Upstate and New York City

Budgets that correspond with automatically renewed cases will have system-generated:

- transaction code 06-renewal(upstate only);
- effective dates that match the new Authorization "From" date and Authorization "To" date;
- budget version number increased by 1. (In NYC, if multiple pending budgets exist, the highest version and store date will be selected and updated); and
- new budget store date.

For upstate districts, the automated renewal budgets are differentiated by the Office code of ABD, the Unit code of RECRT and the Worker code of NYDOH. For New York City the Originating ID will be changed to ART.

C. CNS

Reason Codes

1. Upstate:

Two new reason codes were developed for the automated renewal process:

- 796 Administrative Renewal for Aged, Blind and Disabled (System-Generated)
- C29 Administrative Renewal for Aged, Blind and Disabled (Worker-Manual)

2. New York City:

Two new reason codes were developed for the automated renewal process:

- 415 Administrative Renewal for Aged, Blind and Disabled (System-Generated)
- H99 Administrative Renewal for Aged, Blind and Disabled (Worker-Manual)

VI. **EFFECTIVE DATE**

The provisions of this Administrative Directive are effective January 1, 2012.

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

CNS Paragraph Form

Date: 06.15.11

Program Area	**03**	**(01=PA, 02=FS, 03=MA, 04=HP)**
Paragraph Number	**U0218**	
Version Number	**00001**	
Effective Date	**2011**	
Title	**Administrative Renewal for Aged, Blind and Disabled, Coverage Unchanged**	
Comment		
Reason Code	**796/**	

Every year we must review your case to see if you can continue to get Medicaid. We have reviewed your case and Medicaid will continue unchanged for:

Name: Client I.D. #
Name: Client I.D. #

Also, if we are paying your Medicare Part B premium, we will continue to pay your premium payments.

Our records show that your resources (other than your home) like bank accounts, stocks and bonds are not worth more than the Medicaid resource level of $13,800 (or more than $20,100 for a couple).

Please look at the budget calculation section to see how we figured your income and resources.

If your income has changed or your resources are more than the resource amounts shown above, or you have any changes to report (see the following list of changes), contact your local Department of Social Services by phone, mail or in person by __(10 days from notice date)__. The agency phone number and address are listed at the top of this page.

If you have any questions, call the local Department of Social Services phone number listed above.

If you do not let us know that your income has changed or your resources are more than the amounts shown above, you may have to pay money back to Medicaid.

This decision is based on Regulations 18 NYCRR 360-2.3 and Section 366-a of Social Services Law.

Report changes in income, health insurance, resources or other changes for:

- Any person receiving Medicaid
- Spouse

Income changes we must know about:

- Any change in pay from retirement, pensions, annuities or Veterans benefits
- Any new income

Resource changes we need to know about:

- Any new resource (banks accounts, stocks, bonds, annuities, property, burial contracts)
- Any resource that you have received, sold, opened or closed since your last eligibility review.

Health Insurance changes we need to know about:

- If you have a new health insurance, including Medicare supplements
- Any changes in premium that you pay for health insurance
- Any health insurance coverage that has been cancelled

Other changes that need to be reported:

- name
- marital status
- pregnancy
- immigration status
- home address, mailing address or phone number

To report any changes or if you have any questions, call your local Department of Social Services.

~S/

Debemos hacer una revision anual de su caso para decidir si puede continuar recibiendo Medicaid. Hemos concluido la revision de su caso y hemos determinado que las siguientes personas continuaran recibiendo Medicaid sin cambio alguno:

Nombre: No. de ID del cliente:
Nombre: No. de ID del cliente:

Ademas, si pagamos la cuota de su prima Medicare Parte B, continuaremos haciendo los pagos de esa prima.

Nuestros archivos indican que sus recursos (aparte de su casa) tales como cuentas de banco, acciones y bonos no cuentan con un valor que exceda el indice de recursos de Medicaid de $13,800 (o mas de $20,000 para una pareja).

Consulte la seccion de calculo de presupuesto para entender la manera en que calculamos sus ingresos y recursos.

Si ha habido un cambio en sus ingresos o sus recursos exceden los montos de recursos indicados arriba, o tiene cambios que informar (vea la siguiente lista de cambios), comuniquese con el departamento local de servicios sociales por telefono, por correo o en persona para el _____(10 dias contados a partir de la fecha de la notificacion) . El numero de telefono de la agencia y direccion estan indicados en la parte superior de esta pagina.

Si tiene preguntas, comuniquese con el departamento local de servicios sociales al numero de telefono indicado arriba.

Si usted no nos deja saber que sus ingresos han cambiado o que sus recursos sobrepasan los montos indicados arriba, probablemente tenga que reembolsarle dinero al programa de Medicaid.

Esta decision se basa en Reglamentacion 18 NYCRR 360-2.3 y la Seccion 366-a de la Ley de Servicios Sociales.

Informe de todo cambio en ingresos, seguro de salud, recursos y demas cambios en cuanto a:

- Toda persona que reciba Medicaid
- El conyugue

Cambios en ingresos que usted debe informar:

- Toda cambio en pagos que se reciben de jubilacion, pensiones, anualidades o beneficios a veteranos.
- Un nuevo ingreso

Cambio en recursos que debe informar:

- Todo nuevo recurso (cuenta de banco, acciones, bonos, anualidades, propiedad, contrato de sepelio)
- Todo recurso que usted haya recibido, vendido, abierto o cerrado desde la ultima vez que se realizo su revision de habilitacion.

Cambio en seguro de salud que debe informar:

- Si tiene un nuevo seguro de salud, inclusive un suplemento de Medicare
- Todo cambio en pagos de primas por seguro medico
- Toda cobertura de seguro de salud que haya sido cancelada

Otros cambios de debe informar:

- nombre
- estado civil
- embarazo
- estado migratorio
- domicilio, direccion de correo y numero de telefono

Si desea informar cambios o si tiene preguntas, llame el departamento local de servicios sociales.

CNS Paragraph Form

Date: 09.02.11

Program Area	**03**	**(01=PA, 02=FS, 03=MA, 04=HP)**
Paragraph Number	**U0223**	
Version Number	**00001**	
Effective Date	**2011**	
Title	**Administrative Renewal for Aged, Blind and Disabled, Coverage Unchanged (NYC)**	
Comment		
Reason Code	**415**	

Every year we must review your case to see if you can continue to get Medicaid. We have reviewed your case and we will continue Medicaid coverage unchanged effective _____(MA Authorization "From" Date)_____ for:

Name: Client I.D. #
Name: Client I.D. #

This coverage is subject to any limitations that may be listed below.

Paragraph Selection – Based on RVI value

No Message – Select if new RVI = 1, 9, or blank
Message 1 – Select if new RVI = 2

Since you did not provide proof of resources for the transfer of assets look-back period (up to 60 months), you will not be covered for the following nursing facility services:

- Nursing home care, other than short-term rehabilitation
- Nursing home care provided in a hospital
- Hospice in a nursing home
- Managed long-term care in a nursing home
- Intermediate care facility services

This limitation on coverage applies to Medicaid recipients who are 65 years of age or older, certified blind or certified disabled. Individuals enrolled in a managed care program are eligible to receive the medical services available through their health plan. If you are enrolled in a managed care program, please check your plan member handbook for a list of services covered.

If you start receiving nursing home services on a permanent basis, call the telephone number listed on page 1 immediately. We will then arrange to review documentation of your resources for the transfer of assets look-back period (up to 60 months) to find out if you are eligible for Medicaid coverage for these services. We will also determine if you will have a contribution to the cost of your nursing home care.

Message 2 – Select if new RVI = 3

Since you did not provide proof of income and/or resources, you will not be covered for the following long-term care services:

- Nursing home care, other than short-term rehabilitation
- Nursing home care provided in a hospital
- Hospice in a nursing home
- Managed long-term care in a nursing home
- Adult day health care
- Assisted living program
- Certified home health care, other than short-term rehabilitation
- Hospice in the community
- Managed long-term care in the community
- Personal care services
- Personal emergency response services
- Limited licensed home care
- Private duty nursing
- Consumer directed personal assistance program
- Waiver and other services provided through a home and community-based waiver program

This limitation on coverage applies to Medicaid recipients who are 65 years of age or older, certified blind or certified disabled. Individuals enrolled in a managed care program are eligible to receive the medical services available through their health plan. If you are enrolled in a managed care program, please check your plan member handbook for a list of services covered.

If you need long-term care services, call the telephone number listed on page 1 immediately. We will then arrange to review your resources to find out if you are eligible for Medicaid coverage for these services. You will also need to document your current income.

Use for All:

Our records show that your resources (other than your home) like bank accounts, stocks and bonds are not worth more than the Medicaid resource level of $13,800 (or more than $20,100 for a couple).

Please look at the budget calculation section to see how we figured your income and resources.

If your income has changed or your resources are more than the resource amounts shown above, or you have any changes to report (see the following list of changes), contact your local Department of Social Services by phone, mail or in person by _____(10 days from

notice date)_____. The agency phone number and address are printed at the top of page 1 of this notice.

If you have any questions, call the local Department of Social Services phone number listed on page 1.

If you do not let us know that your income has changed or your resources are more than the amounts shown above, you may have to pay money back to Medicaid.

This decision is based on Regulations 18 NYCRR 360-2.3 and Section 366-a of Social Services Law.

Report changes in income, health insurance, resources or other changes for:

- Any person receiving Medicaid
- Spouse

Income changes we must know about:

- Any change in pay from retirement, pensions, annuities or Veterans benefits
- Any new income

Resource changes we need to know about:

- Any new resource (banks accounts, stocks, bonds, annuities, property, burial contracts)
- Any resource that you have received, sold, opened or closed since your last eligibility review.

Health Insurance changes we need to know about:

- If you have a new health insurance, including Medicare supplements
- Any changes in premium that you pay for health insurance
- Any health insurance coverage that has been cancelled

Other changes that need to be reported:

- name
- marital status
- pregnancy
- immigration status
- home address, mailing address or phone number

To report any changes or if you have any questions, call your local Department of Social Services.

~S/

Debemos hacer una revision anual de su caso para decidir si puede continuar recibiendo Medicaid. Hemos concluido la revision de su caso y continuaremos su cobertura de Medicaid sin cambio a partir del _____(MA Authorization “From” Date)_____ para:

Nombre: No. de ID del cliente:
Nombre: No. de ID del cliente:

Dicha cobertura esta sujeta a toda limitacion que pueda indicarse a continuacion.

Paragraph Selection – Based on RVI value

No Message – Select if new RVI = 1, 9, or blank
Message 1 – Select if new RVI = 2

Debido a que usted no nos proporciono comprobante de recursos referente al traspaso de bienes de un periodo retroactivo (de hasta 60 meses), usted no recibira cobertura por los siguientes servicios de enfermeria:

- Atencion medica en un hogar de convalecencia (nursing home), excepto rehabilitacion a corto plazo.
- Atencion medica tipo hogar de convalecencia (nursing home) proporcionada en un hospital
- Cuidados paliativos en un hogar de convalecencia (nursing home)
- Atencion medica administrada de tratamiento a largo plazo en un hogar de convalecencia (nursing home)
- Centro de servicios de atencion medica intermedia

Dicha limitacion en cobertura aplica a los beneficiarios de Medicaid que tengan 65 anos de edad o mayor, y a personas oficialmente declaradas ciegas o incapacitadas. Las personas que estan inscritas en un programa de cuidados dirigidos de salud, tienen derecho a recibir los servicios de salud que ofrece su plan medico. Si usted esta inscrito en un programa de cuidados dirigidos de la salud, favor de revisar el manual del plan para informarse sobre los servicios que cubre.

Si comienza a recibir servicios de convalecencia (nursing home) de manera permanente, llame inmediatamente al numero de telefono indicado en la pagina 1 arriba. Haremos entonces una revision de documentacion de sus recursos referente al traspaso de bienes de un periodo retroactivo (de hasta 60 meses) para averiguar si reune los requisitos de Medicaid para cobertura de estos servicios. Tambien determinaremos si usted tendra que dar una contribucion contra sus costos de atencion de enfermeria.

Message 2 – Select if new RVI = 3

Dado que usted no nos proporciono cobertura de ingresos/recursos, no recibira cobertura por los siguientes servicios de atencion medica a largo plazo:

- Atencion medica en un hogar de convalecencia (nursing home), excepto rehabilitacion a corto plazo.
- Atencion medica tipo hogar de convalecencia (nursing home) proporcionada en un hospital
- Cuidados paliativos en un hogar de convalecencia (nursing home)
- Atencion medica administrada de tratamiento a largo plazo en un hogar de convalecencia (nursing home)
- Atencion medica diurna para adultos
- Programa de ayuda ocasional
- Atencion medica profesional a domicilio, aparte de la rehabilitacion a corto plazo.
- Cuidados paliativos provistos en la comunidad
- Atencion medica administrada de tratamiento a largo plazo provista en la comunidad
- Servicios de cuidados personales
- Servicio privado de respuesta a emergencias
- Atencion medica profesional domiciliaria limitada
- Servicios privados de enfermeria
- Programa de servicios de asistente personal administrados por el consumidor
- Dispensas y otros servicios de provistos por medio de un programa de dispensas de base domiciliaria y comunitaria

Dicha limitacion en cobertura aplica a los beneficiarios de Medicaid que tengan 65 anos de edad o mayor, y a personas oficialmente declaradas ciegas o incapacitadas. Las personas que estan inscritas en un programa de cuidados dirigidos de salud, tienen derecho a recibir los servicios de salud que ofrece su plan medico. Si usted esta inscrito en un programa de cuidados dirigidos de la salud, favor de revisar el manual del plan para informarse sobre los servicios que cubre.

Si usted necesita servicios de atencion medica a largo plazo, llame inmediatamente al numero de telefono en la pagina 1 arriba. Haremos entonces una revision de sus recursos con objeto de determinar si usted habilita para recibir cobertura de Medicaid para estos servicios. Ademas, tendra que presentar comprobantes de ingresos actuales.

Use for All

Nuestros archivos indican que sus recursos (aparte de su casa) tales como cuentas de banco, acciones y bonos no cuentan con un valor que exceda el indice de recursos de Medicaid de $13,800 (o mas de $20,000 para una pareja).

Consulte la seccion de calculo de presupuesto para entender la manera en que calculamos sus ingresos y recursos.

Si ha habido un cambio en sus ingresos o sus recursos exceden los montos de recursos indicados arriba, o tiene cambios que informar (vea la siguiente lista de cambios), comuniquese con el departamento local de servicios sociales por telefono, por correo o en persona para el _____(10 dias contados a partir de la fecha de la notificacion) . El numero de telefono de la agencia y direccion estan indicados en la parte superior de la pagina 1 de esta notificacion.

Si tiene preguntas, comuniquese con el departamento local de servicios sociales al numero de telefono indicado en la pagina 1.

Si usted no nos deja saber que sus ingresos han cambiado o que sus recursos sobrepasan los montos indicados arriba, probablemente tenga que reembolsarle dinero al programa de Medicaid.

Esta decision se basa en Reglamentacion 18 NYCRR 360-2.3 y la Seccion 366-a de la Ley de Servicios Sociales.

Informe de todo cambio en ingresos, seguro de salud, recursos y demas cambios en cuanto a:

- Toda persona que reciba Medicaid
- El conyugue

Cambios en ingresos que usted debe informar:

- Todo cambio en pagos que se reciben de jubilacion, pensiones, anualidades o beneficios a veteranos.
- Un nuevo ingreso

Cambio en recursos que debe informar:

- Todo nuevo recurso (cuenta de banco, acciones, bonos, anualidades, propiedad, contrato de sepelio)
- Todo recurso que usted haya recibido, vendido, abierto o cerrado desde la ultima vez que se realizo su revision de habilitacion.

Cambio en seguro de salud que debe informar:

- Si tiene un nuevo seguro de salud, inclusive un suplemento de Medicare
- Todo cambio en pagos de primas por seguro medico
- Toda cobertura de seguro de salud que haya sido cancelada

Otros cambios de debe informar:

- nombre
- estado civil
- embarazo
- estado migratorio
- domicilio, direccion de correo y numero de telefono

Si desea informar cambios o si tiene preguntas, llame el departamento local de servicios sociales.