TO: Local District Commissioners, Medicaid Directors, and Services Directors

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: Policy Changes Regarding Verification of Birth Records and Birth Verification Request Letters

Attachment:
Attachment A: Request for Verification of Birth: LDSS to New York State Department of Health, Office of Vital Records
Attachment B: Request for Verification of Birth: LDSS to NYCDOHMH (individuals born in NYC)
Attachment C: Request for Verification of Birth: New York State LDSS to Out-of-State

EFFECTIVE DATE: Immediately

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

The purpose of this General Information System (GIS) message is to provide Local Departments of Social Services (LDSS) with revised agency letters that are to be used when requesting verification of birth records and to clarify and reinforce policy previously released in 07 GIS MA/023.

Changes in Birth Verification Request Letters

The titles to the Birth Verification Request letters (Attachments A, B and C) have been changed. The word “verification” has replaced the words “certificate/certification”. A new box has been added for the applicant or their authorized representative to complete and sign. This authorization allows for the release of birth information to the LDSS. Additionally, the reminder **“**To Be Placed on LDSS Letterhead**”** has been added to each form letter. The purpose of the form letters is to provide statewide language for LDSS to use, on their agency letterhead**,** when requesting verification of birth records.

REMINDER: Districts should be providing Birth Verification Request letters on agency letterhead, with the appropriate local district return address annotated in the box provided on the request letter, to Facilitated Enrollers (FEs) and Family Planning Benefit Program (FPBP) providers with whom they have a Memorandum of Understanding (MOU). FEs and FPBP providers have been instructed to send in-state birth verification requests, with original signatures, to the NYS Department of Health, Office of Vital Records or NYC Department of Health and Mental Hygiene, as appropriate. FEs and FPBP providers should NOT be sending the original request form letter (i.e., Attachment A or B) to the LDSS; FEs and FPBP providers must send a signed and dated **copy** of the completed request letter for birth record to the LDSS for the Medicaid case record as verification that birth information has been requested.

Clarification: Request for Verification of Birth: Out-of-State

We have learned that most states have specific requirements (e.g., forms and fees) for requesting verification of birth that must be adhered to when requesting verification of birth records. Therefore, each LDSS must determine the form, fee, and any additional requirements of the other state and follow the required procedure. The LDSS worker should go to the web site of the specific state from which they are requesting birth verification, download the state's mail-in-form, complete the form and include the appropriate fee.

A listing of other states' requirements can be found at
http://www.cdc.gov/nchs/howto/w2w/w2welcome.htm

Reminder: If FEs and FPBP providers can access on-line forms, they should download the applicable out-of-state request form, complete it according to the instructions provided and obtain the necessary identification/signatures before forwarding the out-of-state request form for Medicaid applicants/recipients to the LDSS. The out-of-state request form must be forwarded to the LDSS because FEs and FPBP providers cannot issue checks for the required out-of-state fee. The LDSS will issue the check and forward the request form to the other state. The LDSS should make a copy of the request for the case file.

Attachment A

[TO BE PLACED ON LOCAL DISTRICT LETTERHEAD]

REQUEST FOR VERIFICATION OF BIRTH
(LDSS to New York State Department of Health, Office of Vital Records)

New York State Department of Health
Certification Unit
Vital Records Section/2nd Floor
800 North Pearl Street
Albany, NY 12204

DATE:_____

_____
NAME OF APPLICANT

_____
CASE NUMBER (LDSS office use only)

TO WHOM IT MAY CONCERN:

PLEASE PROVIDE BIRTH VERIFICATION THAT A RECORD OF THIS INDIVIDUAL'S BIRTH IS ON FILE TO ALLOW US TO PROVIDE SERVICES FROM THIS AGENCY.

(Name) _____,who states he/she was born

on_____/_____/_____, in _____, New York.

His/her mother's maiden name was: _____

His/her father's name was: _____

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I, _____, understand that this information is being requested and shared for the purpose of determining eligibility for the New York State Medicaid Program, Family Health Plus, Child Health Plus and the Prenatal Care Assistance Program.

Signature of Client/Authorized Representative: _____

Date _____

PLEASE RETURN THIS FORM AND THE BIRTH VERIFICATION IN THE ENCLOSED POSTAGE-PAID ENVELOPE AND MAIL IT TO THE LOCAL DEPARTMENT SOCIAL SERVICES AT THE ADDRESS INDICATED IN THE BOX BELOW:

WORKER'S NAME	Program/Section	Phone Number

Attachment B

[TO BE PLACED ON LOCAL DISTRICT LETTERHEAD]

REQUEST FOR VERIFICATION OF BIRTH
(LDSS to New York City Department of Health and Mental Hygiene)

NYC Department of Health and Mental Hygiene
Office of Vital Records
125 Worth Street, CN 4, Room 133
New York, NY 10013-4090

DATE:_____

_____
NAME OF APPLICANT

_____
CASE NUMBER (LDSS office use only)

TO WHOM IT MAY CONCERN:

PLEASE PROVIDE BIRTH VERIFICATION THAT A RECORD OF THIS INDIVIDUAL'S BIRTH IS ON FILE TO ALLOW US TO PROVIDE SERVICES FROM THIS AGENCY.

(Name) _____,who states he/she was born

on_____/_____/_____, in _____, New York.

His/her mother's maiden name was: _____

His/her father's name was: _____

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I, _____, understand that this information is being requested and shared for the purpose of determining eligibility for the New York State Medicaid Program, Family Health Plus, Child Health Plus and and the Prenatal Care Assistance Program.

Signature of Client/Authorized Representative: _____

Date _____

PLEASE RETURN THIS FORM AND THE BIRTH VERIFICATION IN THE ENCLOSED POSTAGE-PAID ENVELOPE AND MAIL IT TO THE LOCAL DEPARTMENT SOCIAL SERVICES AT THE ADDRESS INDICATED IN THE BOX BELOW:

WORKER'S NAME	Program/Section	Phone Number

Attachment C

[TO BE PLACED ON LOCAL DISTRICT LETTERHEAD]

REQUEST FOR VERIFICATION OF BIRTH
(New York State LDSS to Out-of-State)
(Request to be used **only** when other state does not have a required form)

Agency_____ DATE:_____

Address_____

_____ _____
NAME OF APPLICANT

State_____ Zip Code_____ _____
CASE NUMBER (LDSS office use only)

TO WHOM IT MAY CONCERN:

PLEASE PROVIDE BIRTH VERIFICATION THAT A RECORD OF THIS INDIVIDUAL'S BIRTH IS ON FILE IN YOUR STATE TO ALLOW US TO PROVIDE SERVICES FROM THIS AGENCY.

(Name) _____,who states he/she was born on_____/_____/_____, in _____, in the State of _____

His/her mother's maiden name was: _____

Her Place of Birth:_____

His/her father's name:_____

His Place of Birth:_____

Information Requested by:_____

APPLICANT'S AUTHORIZATION TO RELEASE INFORMATION

I, _____, understand that this information is being requested and shared for the purpose of determining eligibility for the New York State Medicaid Program, Family Health Plus, Child Health Plus and the Prenatal Care Assistance Program.

Signature of Client/Authorized Representative: _____ Date _____

Relationship to Client:_____

PLEASE RETURN THIS FORM AND THE BIRTH VERIFICATION IN THE ENCLOSED POSTAGE-PAID ENVELOPE AND MAIL IT TO THE LOCAL DEPARTMENT SOCIAL SERVICES AT THE ADDRESS INDICATED IN THE BOX BELOW.

WORKER'S NAME	PROGRAM/SECTION	PHONE NUMBER