TO: Local District Commissioners, Medicaid Directors, Temporary Assistance Directors, Forms Coordinators, Staff Development Coordinators and CNS Coordinators

FROM: Betty Rice, Director, Division of Consumer and Local District Relations, Office of Medicaid Management

SUBJECT: LDSS-4151 and 4151A: Transitional Medical Assistance (TMA) Mailer Revision

EFFECTIVE DATE: Immediately

CONTACT PERSON: Bureau of Local District Support
Upstate (518) 474-8216 NYC (212) 268-6855

The format of the LDSS-4151: "1st TMA Mailer" and the LDSS-4151A: "2nd TMA Mailer" has been changed. The revised mailers are now in a laser letter format. Copies of the revised mailers are attached.

The revised mailers will replace the current mailers in the near future. This will have no impact on the processing of TMA cases. Districts should continue to follow current policies and procedures, as outlined in OMM/ADM 97-2 and 90 ADM-30.

These mailers are not used by New York City. New York City uses local equivalents.

Upstate districts having questions concerning the content of these documents should call their local district support liaison at 518-474-8216.

YOU MUST FILL OUT THIS REPORT, SIGN THE BACK OF THE FORM, AND RETURN IT TO THE ADDRESS LISTED ON THE BACK BY TO CONTINUE GETTING BENEFITS.

WHEN YOU RETURN THIS REPORT, MAKE SURE THAT THE **LOCAL DISTRICT ADDRESS ON THE BACK** OF THIS REPORT SHOWS IN THE RETURN ENVELOPE WINDOW.

QUESTIONS? CALL:

THIS IS YOUR REPORT FOR:

WE MUST RECEIVE YOUR COMPLETED REPORT BY:

CASE NAME		CASE NUMBER
OFFICE	UNIT	WORKER

GENERAL INSTRUCTIONS

1 ANSWER ALL 3 QUESTIONS .
2 If you answer "Yes" to a question, you must give more information in the space next to the question. If you need more space enclose a separate sheet of paper.
3 Return this form in the enclosed business reply envelope by the above date, or your case may be closed.
4. If you do not answer a question or sign the form, your case may be closed.

QUESTION 1
Did you or anyone in the Medical Assistance case (including step-parents) receive income during the period (previous 4 weeks)?

☐ **NO** ☐ **YES** **If Yes, complete**

1. If anyone in the household received income during the period (previous 4 weeks):
   - Write in the person's name.
   - Write in the source of the income. This can include wages (or pay) received from a job, or other kinds of income such as unemployment benefits, Social Security, child support, Veteran's benefits, boarder/lodgers, and money from friends and relatives.
   - Write in the dates that income was received during the period.
   - Write in the gross amount (before taxes) the person received on the dates listed.
   - If employed, write in the number of hours the person worked each pay period.

Who receives income? _____

Source of income? _____

DATES RECEIVED	GROSS AMOUNT RECEIVED	NUMBER OF HOURS WORKED

Who receives income? _____

Source of income? _____

DATES RECEIVED	GROSS AMOUNT RECEIVED	NUMBER OF HOURS WORKED

2. If anyone in the household is an alien with a sponsor, write in the sponsor's name, income and resources.

3. IF SOMEONE IS WORKING, YOU MUST SEND IN PROOF OF HOW MUCH THAT PERSON MADE DURING THE REPORT PERIOD (include **ALL** pay stubs or other proof of income received during the period). If someone has other income, send in proof of the income. Photo-copies are allowed.

4. If someone in the household stopped working, stopped receiving income, or did not work in any of the previous three months, send in proof.

QUESTION 2
Did anyone move in or out of your household during the period (including births)?

☐ **NO** ☐ **YES** **If Yes,**

Write in any changes in the number of people in your household during the month such as: someone moved in or out, a parent returned home, someone is pregnant, a baby was born, etc., and send in proof of any change. Photo-copies are allowed.

NAMES	WHAT CHANGED	DATE OF CHANGE	OTHER INFORMATION

QUESTION 3
Did anything else change or do you expect any changes in your household during the next three months?

☐ **NO** ☐ **YES** **If Yes, explain on a separate sheet of paper.**

1. Answer this question for any other type of change, such as: marriage, moving, amount paid for child care, resources, or changes you think may happen in the future, or anything else your worker should know.
2. List the weekly amount spent on child care costs $ _____
3. List the amount of transitional child care reimbursement received $ _____
4. Do you have any other health care insurance coverage? ☐ YES ☐ NO
   If yes, list name of company and policy number.

   Insurance Company _____

   Policy Number _____
5. Send in proof of any change. Photo-copies are allowed.

WARNING: If this form is not returned, is late, or is incomplete, your Medicaid coverage may be delayed or discontinued. If you cannot complete or return the form on time, please contact your worker.

CERTIFICATION: I understand that the information I provide on this report may result in changes in my assistance, including reducing the amount of my Medicaid coverage. I understand that such changes may be made without advance notice. I am aware that Federal and State Laws provide for fines and/or imprisonment of any person who fraudulently receives Medicaid to which the person is not entitled.

I understand that I must contact my worker immediately to report any change that occurs or if I have any doubt about needing to report any change.

Recipient's Signature:	Date:	Telephone Number With Area Code: Where You Can Be Reached

Fill out & Return in The Envelope Provided

When you return this Report, make sure you can see this address in the return envelope window ⟶

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WARNING:

COMPLETE, SIGN, AND RETURN THE ENCLOSED FORM IMMEDIATELY. IF THIS FORM IS NOT RETURNED, IS LATE, OR IS INCOMPLETE, YOUR MEDICAL ASSISTANCE COVERAGE MAY BE DELAYED, REDUCED OR DISCONTINUED. IF YOU CANNOT COMPLETE OR RETURN THE FORM ON TIME, PLEASE CONTACT YOUR WORKER.

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(CONTINUED ON OTHER SIDE)

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