LDSS NAME
MAILING ADDRESS
XXXX, NEW YORK XXXXX

Date_____

Long-Term Care Documentation Requirement Checklist

Case Name: _____ **Rep Name:** _____
Address: _____ **Due Date:** _____
_____ **Case Number:** _____

On _____, you requested Medical Assistance coverage of long-term care services. In order for us to determine your eligibility for long-term care services your worker must receive the following information checked below no later than the above due date. Failure to submit the information may result in the denial of Medical Assistance coverage for long-term care services. If you cannot obtain these items by the above date, you must contact your worker to request a brief extension. Verification of your attempt to obtain these documents may be required prior to granting an extension.

- ❑ Complete, sign and return the enclosed "Long-Term Care Change In Need Resource Checklist". Since you requested Medicaid coverage for community-based long-term care, you must provide proof of the current value of each resource checked "Yes".

- ❑ Complete, sign and return the enclosed "Long-Term Care Change In Need Resource Checklist". Since you requested Medicaid coverage for nursing facility services, you must provide proof of the value of each resource checked "Yes" for the period _____ to _____.

    - ❑ Document all checks and withdrawals over $_____.

    - ❑ Copies of your last three years tax returns (including 1099's and all schedules and forms).

_____ _____
Social Welfare Examiner Phone Number

Enclosure