# Access NY Supplement A

## This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.
  This includes care in a hospital that is equivalent to nursing home care.

**Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.**

**INSTRUCTIONS:**

- Sections A through F must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections G through I.

## A. This Supplement is being completed for:

| Legal Last Name | Legal First Name | MI | Social Security Number | Marital Status |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Note: The remaining questions are for the person(s) named above.**

## B. Blind, Disabled or Chronically ill

1. Are you chronically ill? ☐ Yes ☐ No
   *(Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)*

2. Are you Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
   **(If yes, send proof.)**

3. If you are disabled and working, are you interested in applying for the MBI-WPD program? ☐ Yes ☐ No
   *The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.*

## C. Are you living in an adult home or assisted living facility? ☐ Yes ☐ No

## D. Resources/Assets (check the box that applies):

☐ You are applying for Medicaid coverage but not coverage of community-based long-term care services. You may attest to the amount of your resources. You are not required to submit documentation of your resources. This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☐ You are applying for coverage of community-based long-term care services. You must submit documentation of the current amount of your resources.* These services include:

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

**Note: Some examples of home and community-based programs that provide waivers and other services are Traumatic Brain Injury Program and Long Term Home Health Care Program.**

☐ You are institutionalized and applying for coverage of nursing home care. You must submit documentation of your resources back to February 1, 2006, or the past 60 months, whichever is less.

* You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

List all resources owned by you and/or your spouse/parent(s), including custodial accounts. **If applying for coverage of nursing home care,** also list any accounts closed since February 1, 2006, or in the past 60 months, whichever period is shorter; include balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more. **Note:** Medicaid retains the right to review all transactions made during the transfer look-back period.

### 1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs):

| Bank Name and Account Number | Name of Owner(s) | Current Dollar Amount | Closed Account Balance/ Date Closed |
|---|---|---|---|
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |

### 2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh):

| Account Number | Name of Owner(s) | Type/Institution | Current Dollar Amount | Pay Out |
|---|---|---|---|---|
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |

**3. Life Insurance Policies:**

| Insurance Company | Policy Number | Name of Owner(s) | Cash Value | Face Value |
|---|---|---|---|---|
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |

**4. Annuities, Stocks, Bonds, Mutual Funds:**

| Name of Owner(s) | Company | Date Purchased | Value |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |

**5. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the schedule of trust assets.**

| Name of Trust | Grantor | Trustee(s) | Assets | Beneficiary | Income |
|---|---|---|---|---|---|
| | | | $ | | $ |
| | | | $ | | $ |
| | | | $ | | $ |

**6. Burial Assets/Burial Contracts: (Include copies)**

Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have money in a bank account set aside for a burial fund? ☐ Yes ☐ No

If **yes**, in what account(s) is your and/or your spouse's burial fund?

| Bank Name and Account Number | Name of Owner(s) | Value |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |

Do you have life insurance to be used as your burial fund? ☐ Yes ☐ No

If **yes**, what is your policy number(s)? _____

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

Does your spouse have life insurance to be used as a burial fund? ☐ Yes ☐ No

If **yes**, what is the policy number(s)? _____

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

**7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles.**

| Name of Owner(s) | Year/Make/Model | Fair-Market Value | Amount Owed | In Use? |
|---|---|---|---|---|
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |

**8. Equity Value in Home:**

If you own your home, what is the equity value in your home? $ _____

**Note:** Equity value is the fair market value less any outstanding liens, mortgages, etc.

**9. List Any Other Resources:**

| Resource Type | Name of Owner(s) | Value |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |
| | | $ |

## E. Real Property (other than your home)

Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply) ☐ Yes ☐ No

| ☐ Rental Property | ☐ Vacation Property | ☐ Time Share | ☐ Vacant Land | ☐ Other Property Rights (In or outside of New York State) |
|---|---|---|---|---|

If **yes,** please answer the following questions.

| Name and Address of Owner(s) | Address of Property | Type of Ownership (Check one) | Equity value |
|---|---|---|---|
| | | ☐ Individual ☐ Joint tenancy ☐ Life estate | $ |
| | | ☐ Individual ☐ Joint tenancy ☐ Life estate | $ |
| | | ☐ Individual ☐ Joint tenancy ☐ Life estate | $ |
| | | ☐ Individual ☐ Joint tenancy ☐ Life estate | $ |

## F. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No
2. If you are in a medical facility and own your home, do you intend to return to your home? ☐ Yes ☐ No
3. If **no,** is anyone living in the home? ☐ Yes ☐ No

Who is living in the home? _____

How is this person related to you and/or your spouse? _____

If you and/or your spouse's child (of any age) is living in the home, is the child disabled? ☐ Yes ☐ No

**Note:** If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility.

**STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, the last page of this document MUST be signed.**

## G. Applicant Living in a Long-Term Care Facility/Nursing Home

| Name of Facility | Date Admitted / / | Telephone Number ( ) | |
|---|---|---|---|
| Street Address | City | State | Zip |
| Applicant's Previous Address | City | State | Zip |

## H. Asset Transfers

1. Transfers

a. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

b. Are you in the process of selling property? ☐ Yes ☐ No

c. Did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No
If **yes,** when? _____

d. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

e. Did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No
If **yes,** when? _____

f. Did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No
If **yes,** when? _____

2. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust? ☐ Yes ☐ No

**If you answered yes to any of the questions above, explain the transfer(s) below. Attach additional sheets of paper, if needed.**

| Description of Asset (including income) | Date of Transfer | Transferred to Whom | Amount of Transfer |
|---|---|---|---|
| | | | $ |
| | | | $ |
| | | | $ |
| | | | $ |

3. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? **If yes, send copy of agreement.** ☐ Yes ☐ No

## I. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No
**If yes, send copies of these returns.**

**Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.**

**Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within the transfer of assets look-back period (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and determined otherwise eligible for Medicaid coverage of nursing facility services, may cause the individual to be ineligible for nursing facility services for a period of time.**

**As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.**

**In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse on or after February 8, 2006, may be treated as a transfer unless:**

- **The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or**
- **The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.**

**If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.**

**If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.**

**I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.**

X _____
SIGNATURE OF APPLICANT/REPRESENTATIVE

X _____
DATE SIGNED

X _____
SIGNATURE OF APPLICANT'S SPOUSE

X _____
DATE SIGNED