IMPORTANT NOTICE CONCERNING MEDICAID ELIGIBILITY FOR AN ADULT WHO WAS IN FOSTER CARE

DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

New York State of Health Account Holder's Name _____
Application Date_____

The enclosed application (LDSS-4220) is required to authorize Medicaid coverage for the following individuals:

Name _____
Name _____

This application is being sent to you because you indicated on the New York State of Health (Marketplace) application that you were in foster care in New York State at age 18 and were receiving Medicaid. We have verified this. As a result, you may be eligible for Medicaid up to age 26 without regard to your income, as long as you live in New York State.

However, in order for you to get Medicaid coverage, you will need to complete the following sections of the application included with this notice and provide required documentation: A, B, D, G, and I**.** You must also sign and date the application.

You may call your Local Department of Social Services for help with this application. You must return the application to the address listed above by _____. You may wish to keep a copy of this application for your records.

If we do not receive the signed and dated application, we will not be able to authorize Medicaid coverage and your application will be denied.

MAKE SURE YOU SIGN THE APPLICATION. RETURN ALL PAGES BY MAIL OR IN PERSON TO YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES OFFICE.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS