CNS Paragraph Form

Date: 10.27.2014

Program Area	**03**	**(01=PA, 02=FS, 03=MA, 04=HP)**
Paragraph Number	**Y0136**	
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Title	**Renewal Letter, Individual Transferred from New York State of Health (NYSoH)**	
Comment		
Reason Code	**H2W**	

CONTINUING YOUR MEDICAID BENEFITS

The following individuals are required to have their Medicaid eligibility determined on a different basis that takes into account both income and certain deductions that were not applied by the Marketplace:

Name	Client I.D. #
Name	Client I.D. #
Name	Client I.D. #

Your Medicaid eligibility must be determined on a different basis because:

- you are age 65 or older and not a parent or caretaker relative; or
- you are 19 or 20 years of age and in receipt of Medicare, are not living with a parent, are not pregnant or a caretaker relative; or
- you are at least 21 years of age and in receipt of Medicare, and are not a parent or caretaker relative or pregnant; or
- you have excess income making you ineligible for coverage through New York's health benefit exchange, New York State of Health.

In order for us to determine your continued eligibility for Medicaid, you must complete the attached form.

You must answer **all** the questions and return this form and any required documentation to the following address by **(date)**.

_____

_____

_____

- If you do not complete and return this form, you will lose your health insurance. If we are paying your health insurance premiums, we will also stop making these payments.
- This form is not complete until you sign and date it.
- Please read the Terms, Rights, and Responsibilities.

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***Important Instructions-Please Read ***

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- To determine your eligibility, the amount of income you report will be compared to available computer matches.

- **You do not need to send proof of** income and/or resources at this time unless the renewal form says you must. However, since the amount you report may not match the amount found in the computer matches, you may wish to submit proof of your income to be sure that you receive the correct coverage.

- You may be asked to provide proof of your income and/or resources at a later date. If needed, you will be contacted and told what to send in. The attached "Documentation Checklist" shows you the things you can use as proof of these items.

You may call your local department of social services for help with this form. If you need help finding contact information for your local Department of Social Services, please call the NY State Medicaid Help Line at 1-800-541-2831 or visit the NY State Department of Health Web site at http://www.health.ny.gov/health_care/medicaid/ldss.htm.

MAKE SURE YOU ANSWER EVERY QUESTION AND SIGN THE FORM.

RETURN ALL PAGES AND ANY REQUIRED DOCUMENTATION BY MAIL OR IN PERSON TO THE SOCIAL SERVICES OFFICE.

YOU DO NOT NEED TO COME IN FOR AN INTERVIEW.

RENEWAL FOR MEDICAID

1. Has your address or telephone number changed since you last applied for/renewed your health care coverage?

[_] No. [_] Yes. My new address and/or telephone number is:

_____

House # Street Apt. # PO Box#

_____

City State Zip

_____

Telephone #

[_] Check here if homeless.

If you do not receive mail where you live, please write your mailing address below:

_____

House # Street Apt. # PO Box#

_____

City State Zip

My telephone number is: _____ [_] Home [_] Cell [_] Work [_] Other

Another phone number where I can be reached is: _____ [_] Home [_] Cell [_] Work [_] Other

2. Who else lives with you? Write the full legal name(s) below and the relationship to the person listed on the first page. (For example, spouse, parent/step-parent, child and their date of birth and gender.)

If anyone listed below wants to apply for health insurance, write their social security number below.

Name	**Relationship**	Date of Birth	Gender (M/F)	SSN (If you have one)	Does this person want health insurance?
_____	_____	_____	___	_____	__**Yes** ___**No**
_____	_____	_____	___	_____	__**Yes** ___**No**
_____	_____	_____	___	_____	__**Yes** ___**No**
_____	_____	_____	___	_____	__**Yes** ___**No**

Identity and U. S. citizenship, satisfactory immigration status or Lawful Presence must be documented. If anyone listed above who is applying for health insurance is declaring to be a U. S. citizen or national and provides his or her SSN or proof that an SSN was applied for, Medicaid will verify his or her SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, **proof** of identity and U. S. citizenship status may be required.

Anyone listed above who is applying for health insurance and is not a U.S. citizen must **send proof** of identity and immigration status.

Proof of income is also required.

Include anyone applying for health insurance when you answer the rest of the questions on this form.

3. Is anyone listed on the first page or in question 2, pregnant?
[_] No. [_] Yes.

Who? Expected due date:

_____ _____

_____ _____

4. Has anyone who had health insurance coverage **lost** the coverage?
[_] No. [_] Yes.

Who?	Insurance company name:	Date Coverage Ended:
_____	_____	_____

a. Has anyone **started** being covered by health insurance (including Medicare or long-term care insurance) other than Medicaid? We may be able to pay the cost of your health insurance premiums if it is cost effective.
[_] No. [_] Yes.

Name of Insured	Premium amount:	Paid How Often:
_____	$_____	_____

You must send a copy of the front and back of the insurance card and/or Medicare card (red, white and blue card) for each person and a copy of the insurance policy.

b. If you are not insured through your job now, does your job offer health insurance? We may be able to pay the cost of your health insurance premiums if it is cost effective.
[_] No. [_] Yes.

If yes, list employer name, address, and telephone number below:

_____
_____
_____
_____

5. Since you last applied/renewed, has anyone become blind, or disabled, or does anyone now have a chronic illness or special health care need? 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.

[_] No. [_] Yes. If yes, who? _____

Explain: _____
_____

a. If you are blind or disabled do you pay special expenses (non-medical) in order to work?
[_] No. [_] Yes. **(You must send in receipts for these expenses.)**

b. Does anyone who is renewing or applying have a pending lawsuit due to an injury? [_] No. [_] Yes.

If yes, who? _____

c. Does anyone renewing or applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else, (that could be covered by insurance)? [_] No. [_] Yes.

If yes, who? _____

6. If there is a parent or spouse living outside of the home, please answer the following questions.

a. Since you last applied/renewed, has the spouse or parent of someone renewing moved out of the home?

[_] No (Go to Question 6b.) [_] Yes. Give the following information, if known.

Name: Parent_____ Spouse _____
Date of Birth _____ Social Security Number _____
Address _____
Telephone number_____
Employer name and Address_____
_____
Parent/Spouse of _____

Note: Families who are renewing for their children and pregnant women are NOT required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor, or a spouse living outside the home to be eligible for health insurance. If you believe that providing information regarding the absent parent or spouse could cause physical or emotional harm to you or your child, you may have "good cause" for not cooperating.

[_] Check here if you fear physical or mental harm if the absent parent or spouse is contacted and you are claiming good cause. If you checked this box, you will be contacted to explain your reason and to provide proof.

b. Since you last applied/renewed, do you have any information that you have not previously given us to help us find a spouse or parent who does not live in the home (e.g., home address or work place)?
[_] No. [_] Yes. **Give the following information, if known.**

Name: Parent_____ Spouse _____
Home Address _____
Employer name and Address _____
_____
Parent/Spouse of _____

Name: Parent_____ Spouse _____
Home Address _____
Employer name and Address _____
_____
Parent/Spouse of _____

7. Write the types of income (money) and the amount received by everyone in the household. See the documentation checklist for examples of income. **Write the amount before any taxes or other deductions; include tips/commissions.**

If you or anyone renewing or applying is self-employed, check here: [_]

Name	Type of Income/Source (if income is from employment)	Name of Employer	How Much (before taxes /deductions. Include tips /commissions)	How Often (Weekly/2 weeks/Monthly)
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____

Check the box if the statement applies to you:
[_] I do not get paychecks or pay stubs. [_] I get paid in cash.

If you or any adult in the household does not have income, tell us who_____

If there is no income listed above, please explain how you are living:
(For example: living with friend or relative.)
_____

a. Have you or anyone who is applying changed jobs or stopped working in the last three months?
[_] No. [_] Yes. If yes, who? _____
If yes, last job was: Date: _____/___/___ Name of Employer: _____

b. Are you or anyone who is renewing or applying a student, in a vocational, undergraduate, or graduate program?
[_] No. [_] Yes. If yes: [_] Full Time [_] Part Time [_] Undergraduate [_] Graduate
Student's name: _____

c. Do you or anyone who is renewing or applying pay for health insurance premiums, Medicare premiums, court ordered support, or child/adult care expenses?
[_] No. [_] Yes. If yes, fill out below and send proof of each expense.

Type of expense	Name of person paying the expense	How much is being paid	How often is the expense paid (Ex. Weekly, monthly)
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____

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.

Are you applying for MBI-WPD?

[_] No. [_] Yes.

If YES, you must submit proof of your employment. See the enclosed Documentation Checklist for the documents you can use to prove you are employed.

8. Has your share of the monthly housing payment (such as rent or mortgage, including property taxes) changed since you last applied/renewed for your healthcare coverage?

[_] No. [_] Yes. My new share of the monthly housing payment is $_____.

If you pay for water separately, how much do you pay? $_____ **Send proof** of water bill.

Do you receive free housing from your employer? [_] No. [_] Yes.

9. **Proof of identity, United States citizenship, ~~or~~ satisfactory immigration status or Lawful Presence is a requirement for Medicaid eligibility.**

If you are declaring to be a U. S. citizen, but you have not provided proof of U. S. citizenship, provide your SSN or proof that an SSN was applied for, and Medicaid will verify your SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, proof of identity and U. S. citizenship status may be required. Proof of identity and citizenship requires original documents or copies certified by the issuing agency.

a. Has anyone renewing not provided proof of U.S. citizenship? Who? SSN (If you have one)

_____ _____
_____ _____
_____ _____

If you are an immigrant, but have not provided proof of your identity and immigration status, or if your immigration status has changed you must send us proof. Send proof from the federal immigration agency showing your current immigration status.

b. Has the immigration status of anyone renewing changed? Who? SSN (If you have one)

_____ _____
_____ _____
_____ _____

c. If you were pregnant and not a citizen, qualified alien or have Lawful Presence, you will no longer be eligible for Medicaid 60 days after your pregnancy ends (called the post-partum period). If you have not proven your U. S. citizenship or satisfactory immigration status during the time you received Medicaid and you do not send in proof with this renewal, you are guaranteed 24 months of family planning services under the Family Planning Extension Program.

Should you require Medicaid to cover treatment of an emergency medical condition or for a pregnancy, you may become eligible for Medicaid, regardless of your citizenship and immigration status.

[___] Check this box if you no longer want Medicaid or Family Planning Extension Program benefits after your 60 day post-partum period ends.

10. **You do NOT have to complete this section if you are under age 65 and not receiving Medicare benefits or are the parent or caretaker relative of a child under age 18.**

List all resources (Resources include money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, or property that someone owns. Do not list your home).

If you do not have any resources, please write "NONE" under "Resource Type."

What are your current resources?

Resource Type	Value	Owner	Bank/Company Name
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____
_____	$ _____	_____	_____

Do you want to receive Medicaid coverage for long-term care services, such as home care or personal care services?
[_] No.

[_] Yes. If yes, you need to send **proof** of your current resources.

If you want to receive Medicaid coverage for long-term care services and 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.) $_____

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The New York Medicaid program must tell you how we use, share, and protect your health information. The New York Medicaid program includes regular Medicaid and Medicaid Managed Care. The program is administered by the New York State Department of Health and the Local Department of Social Services.

A copy of the Notice may be obtained at your local Department of Social Services.
It is also available at:

http://www.health.ny.gov/health_care/medicaid/program/hipaa/notepriveng.htm

READ THE TERMS, RIGHTS AND RESPONSIBILITIES SECTION, SIGN AND DATE THIS FORM AND RETURN IT BY THE DATE SHOWN ON PAGE ONE.

By signing this form, I understand that each person listed will be enrolled in the appropriate program, if eligible. I have also read and understand these Terms, Rights and Responsibilities. I certify under penalty of perjury that everything on this renewal form is the truth as best I know.

_____ _____

SIGNATURE of Applicant or Representative DATE

_____ _____

SIGNATURE of other applying adult DATE

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying to renew Medicaid and/or Family Planning Benefit Program coverage.

I understand that I must provide the information needed to prove my eligibility for each program. I agree to immediately report any changes to the information on this form. If I am unable to get the information, I will tell the social services district. The social services district may be able to help in getting the information. I understand that workers from the programs for which family members or I are renewing may check the information given by me on this form. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.

I understand that Medicaid and/or Family Planning Benefit Program coverage will not pay medical expenses that insurance or another person is supposed to pay, and that I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.

I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.

I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.

I understand that if my child is on Medicaid, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program.

I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS I certify under penalty of perjury, by signing my name on this form, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. The term "satisfactory immigration status" means an immigration status that does not make the person ineligible for benefits. **Important Information**: The United States Citizenship and Immigration Services (USCIS) has said that enrollment in Medicaid CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member or travel in and out of the country (except if Medicaid pays for long term care in a place like a nursing home or psychiatric hospital). **The State will not report any information on this application to the USCIS.**

SOCIAL SECURITY NUMBER All applicants must provide a social security number or proof that they have applied for one or tried to apply for one. The only exceptions are pregnant women, undocumented immigrants and temporary non-immigrants applying for the treatment of an emergency medical condition, and certain battered immigrants. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within Department of Social Services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient.

RELEASE OF MEDICAL INFORMATION I consent to the release of any medical information about me and any members of my family for whom I can give consent: by my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid; and, by my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

MEDICAID MANAGED CARE If I am adding a family member to a Medicaid case and I live in a county that requires Medicaid recipients to join a health plan, I understand that this family member will be enrolled in the same health plan as my family, unless he or she is exempt or excluded.

RELEASE OF EDUCATIONAL RECORDS I give permission to the Local Department of Social Services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

EARLY INTERVENTION PROGRAM If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local Department of Social Services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

I consent to sharing this information with any school-based health center that provides services to the applicant(s).

OFFICE USE ONLY

Worker Signature	Supervisor Signature	Case Disposition

DOCUMENTATION CHECKLIST

PROOF OF INCOME Anyone new applying for health insurance must send proof of current income. However, any recipient may choose to send proof of current income if they want to.

Earned Income from Employer……..	Current paycheck/stubs (~~4~~ four consecutive weeks) **or** letter from employer
Self-Employment Income……	Current signed income tax return and all schedules **or** record of earnings and expenses
Rental/Roomer-Boarder Income……..….	Letter from roomer, boarder, tenant **or** check stub
Unemployment Benefits……..	Award letter/certificate, monthly benefit statement, correspondence from the NYS Department of Labor, printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us), **or** copy of Direct Payment Card with printout
Private Pensions/Annuities……...…….	Statement from pension/annuity
Social Security……..	Award letter/certificate, annual benefit statement, **or** correspondence from Social Security Administration
Employment Based Sick Pay/Disability Income	Award letter/certificate, benefit check stub, **or** correspondence from source of income
Child Support/Alimony…….	Letter from person providing support, letter from court, child support/alimony check stub, copy of NY Eppicard with printout, copy of child support account information from www.newyorkchildsupport.com, **or** copy of bank statement showing direct deposit
Worker's Compensation……....……	Award letter **or** check stub
Veteran's Benefits…….	Award letter, benefit check stub, **or** correspondence from Veterans Administration
Military Pay……	Award letter **or** check stub
Interest/Dividends/Royalties……	Current statement from bank, credit union, or financial institution, letter from broker, letter from agent, **or** 1099 or tax return (if no other documentation is available)
Support from other Family Members…….	Signed statement or letter from family member
Income from a trust.....	Trust document

PROOF OF EMPLOYMENT (Medicaid recipients currently enrolled in the Medicaid Buy-In program must provide documentation of employment.)

- Current paycheck/stub; **or**
- Detailed written statement from employer; **or**
- W-2 form; **or**
- Income tax return.

CHILD CARE / DEPENDENT CARE EXPENSES Anyone new applying for health insurance must send proof of this expense, if applicable.)

- Written statement from day care center or other child/adult care provider; **or**
- Canceled checks or reciepts that show your payments.

HEALTH INSURANCE PREMIUMS (Provide, if applicable.)

Letter from employer Premium statement Pay stub

PRIVATE OR EMPLOYER BASED HEALTH INSURANCE (Provide only if new or changed since you last applied/renewed)

- Insurance policy; **or**
- Medicare Card (Red, white and blue card).
- Premium statement; **or**
- Insurance Card; **or**
- Termination letter; **or**

SPECIAL WORK EXPENSES FOR BLIND/DISABLED

If you are blind or disabled and must pay special non-medical expenses in order to work~~,~~ (for example, you need special equipment or transportation), send in receipts that show what the expenses are and who provides them.

CITIZENSHIP/IDENTITY

NOTE: Anyone new applying for health insurance must prove identity, but does not have to send proof of citizenship or immigration status if he/she is:

- Pregnant; **or**
- An undocumented immigrant applying for Medicaid coverage because of an emergency medical condition. (See Medical Assistance section of Book 2, LOCAL DEPARTMENT OF SOCIAL SERVICES-4148B for more information on citizenship or immigration status).

Documents which Establish both Citizenship and Identity: Identity and U. S. citizenship or satisfactory immigration status must be documented if anyone new is applying for health insurance. If you are applying for health insurance and are declaring to be a U. S. citizen or national, if you provide your SSN or proof that an SSN was applied for, Medicaid will verify your SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, proof of identity and U. S. citizenship status may be required. All documents must be originals or copies certified by the issuing agency. For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, American Samoa, Swain's Island and, if born on or after certain dates, Puerto Rico, Guam, the U. S. Virgin Islands and the Northern Mariana Islands. **(If you provide one of the following, no other document is required for proof of citizenship/identity.)**

- U.S. passport book/card; **or**
- Certificate of Naturalization (N-550 or N-570); **or**
- Certificate of U.S. Citizenship (N-560 or N-561); **or**
- NYS Enhanced Driver's License (EDL); **or**
- Native American Tribal Document, Certificate of Degree of Indian blood or other Native American/Alaska native tribal document with photo.

Documents which Establish Citizenship but also require one identity document

- U.S. Birth Certificate
- Certification of birth issued by Department of State (FS-545 or DS-1350); **or**
- Report of Birth Abroad (FS-240); **or**
- U.S. Citizen ID Card (I-197 or I-179); **or**
- Religious/school records; **or**
- Military record of service showing U.S. place of birth; **or**
- Final adoption decree; **or**
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.

Documents which Establish Identity

- State driver's license or ID card with photo; **or**
- ID card issued by a Federal, State, or local government agency; **or**
- U.S. Military card or draft record or U.S. Coast Guard Merchant Mariner Card; **or**
- School ID card with a photo; **or**
- Verified school, nursery or daycare records (for children under 16); **or**
- Clinic, doctor or hospital records (for children under 16).

<u>Current Immigrant Status</u> must be provided for any new person applying or any person renewing whose status has changed in the past 12 months or you must prove that you are in a satisfactory immigration status or Lawfully Present.

<u>Immigration Status/Identity</u>

- I-551 Permanent Resident Card ("Green Card"); **or**
- I-766 Employment Authorization Card.

<u>Immigration Status, but require an additional identity document</u>

- I-94 Arrival/Departure Record; **or**
- USCIS Form I-797 Notice of Action; **or**
- Evidence of Continuous U.S. residence prior to January 1, 1972.

These lists are not all inclusive. If you do not have one of these documents, please contact your local department of social services for information on other documents that can be used.