NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

# Renewal for Medicaid (Chronic Care)

**DIRECTIONS**

1. **Please Print Clearly. Do Not Write in the Shaded Areas.**
2. Fill out the form completely and accurately.
3. **Sign the Form on the Back Page.**
4. Return this recertification to the address listed.

**LOCAL DISTRICT NAME AND ADDRESS**

**RECERTIFICATION REFLECTS**

- ☐ No change
- ☐ Change
- ☐ Outstanding documentation needed

**CENTER/OFFICE** | **UNIT ID** | **WORKER ID** | **CASE TYPE** (2 0) | **CASE NUMBER** | **DISTRICT**

**CASE NAME** | **NAME OF INDIVIDUAL INTERVIEWED** | **CATEGORIES**

**MA ELIGIBILITY DATES**

| From | | | To | | |
|---|---|---|---|---|---|
| Month | Day | Year | Month | Day | Year |
| | | | | | |

## RECIPIENT'S INFORMATION

| FIRST NAME | MI | LAST NAME | DATE OF BIRTH Month | Day | Year |
|---|---|---|---|---|---|
| | | | | | |

| SEX ☐ MALE ☐ FEMALE ☐ X | GENDER IDENTITY (OPTIONAL)* (SEE CODES BELOW) |
|---|---|
| | |

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth. Gender Identity Codes: **M**-Male, **F**-Female, **N**-Non-Binary or Non-Conforming, **X**-X, **T**-Transgender, **D**-Different Identity: Describe your Identity in space provided.

| SOCIAL SECURITY NUMBER | LIST OTHER NAMES RECIPIENT HAS BEEN KNOWN BY | ONC |
|---|---|---|
| | | |

| NAME AND ADDRESS OF RECIPIENT'S FACILITY |
|---|
| |

## RECIPIENT'S SPOUSE'S INFORMATION

| SPOUSE'S FIRST NAME | MI | SPOUSE'S LAST NAME | DATE OF BIRTH Month | Day | Year |
|---|---|---|---|---|---|
| | | | | | |

| SPOUSE IS DECEASED ☐ YES ☐ NO | IS SPOUSE APPLYING/RECERTIFYING/RECEIVING? ☐ YES ☐ NO | SPOUSE'S SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |

| SPOUSE'S ADDRESS | SPOUSE'S PHONE NUMBER ( ) |
|---|---|
| | |

| LIST AND OTHER NAMES BY WHICH YOUR SPOUSE HAS BEEN KNOWN | ONC |
|---|---|
| | |

| LIST ANY DEPENDENT FAMILY MEMBER WHO IS LIVING WITH YOUR SPOUSE | FAMILY MEMBER'S SOCIAL SECURITY NUMBER | FAMILY MEMBER'S DATE OF BIRTH Month | Day | Year |
|---|---|---|---|---|
| | | | | |

| WHAT IS THE FAMILY MEMBER'S RELATIONSHIP TO YOU OR YOUR SPOUSE? |
|---|
| |

| NAME AND ADDRESS OF PERSON COMPLETING THIS FORM (If OTHER THAN Recipient or Recipient's Spouse) | PERSON'S PHONE NUMBER ( ) |
|---|---|
| | |

## RESOURCES

LIST ANY RESOURCES THAT THE RECIPIENT MAY HAVE:

| | YES | NO | $ VALUE | ACCOUNT NUMBER | LOCATION |
|---|---|---|---|---|---|
| Personal Incidental Account (PIA) | ☐ | ☐ | | | |
| Savings Account (Checking/Savings/ Certificate of Deposit in Bank, Credit Union) | ☐ | ☐ | | | |
| | ☐ | ☐ | | | |
| | ☐ | ☐ | | | |
| Expect Lawsuit Settlement, Inheritance | ☐ | ☐ | | | |
| Trust Fund | ☐ | ☐ | | | |
| Life Insurance | ☐ | ☐ | | | |
| Annuity | ☐ | ☐ | | | |
| Stocks, Bonds, Savings Bonds | ☐ | ☐ | | | |
| Real Estate (Including Vacation Property and Homestead) | ☐ | ☐ | | | |
| Income-Producing Property | ☐ | ☐ | | | |
| Non-Income-Producing Property | ☐ | ☐ | | | |
| Own Home | ☐ | ☐ | | | |
| Mutual Fund | ☐ | ☐ | | | |
| IRA, KEOGH, 401-K, Deferred Comp. | ☐ | ☐ | | | |
| Other Pension or Retirement Account | ☐ | ☐ | | | |
| Burial Fund, Burial Trust, Burial Space (Cemetery Plot), Funeral Agreement | ☐ | ☐ | | | |
| Other Resources (Please Specify) | ☐ | ☐ | | | |
| Motor Vehicle | ☐ | ☐ | | Year / Make | Model |

HAVE YOU OR YOUR SPOUSE SOLD, GIVEN AWAY, OR TRANSFERRED ANY CASH, INCOME, REAL ESTATE, OR OTHER ASSET WITHIN THE PAST 60 MONTHS?

| YES | NO | ASSET | $ VALUE | WHO DID IT GO TO? |
|---|---|---|---|---|
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |

**Do Not Write in the Shaded Area.**

## INCOME

| LIST ANY INCOME THAT THE RECIPIENT, RECIPIENT'S SPOUSE, OR DEPENDENT FAMILY MEMBER, MAY HAVE: | RECIPIENT'S INCOME | | | SPOUSE'S INCOME | | | FAMILY MEMBER'S INCOME | | |
|---|---|---|---|---|---|---|---|---|---|
| | YES | NO | $ AMOUNT | YES | NO | $ AMOUNT | YES | NO | $ AMOUNT |
| Social Security/Railroad Retirement | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Pension | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Veteran's Pension | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| IRA, KEOGH, 401-K, Deferred Compensation | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Alimony/Spousal Payment | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Mortgage/Rental Income | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Annuity | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Interest from Bank Accounts, Mutual Funds, Stocks, Credit Unit | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Dividends from Stocks, Bonds, Mutual Funds | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Other Income such as Disability Benefits, SSI, Employment, etc. (Please specify) | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |
| Do you expect to receive income from a trust, Lawsuit Settlement, Inheritance, etc.? | ☐ | ☐ | | ☐ | ☐ | | ☐ | ☐ | |

## HEALTH INSURANCE

| | | |
|---|---|---|
| Do you have Medicare (Red, White, and Blue card)? ☐ Yes ☐ No If Yes, ☐ Part A ☐ Part B | | |
| Does your spouse or dependent family member have Medicare? ☐ Yes ☐ No If Yes, ☐ Part A ☐ Part B | | |
| Are you, your spouse or a dependent family member covered under any health insurance plan, such as plans provided by employer, unions, retirement system; coverage under support order, private insurance plans or VA? ☐ Yes ☐ No | | |
| Name of Covered Person(s) | | |
| Who Pays the Premium | | |
| Name of Insurance Company | | |
| Policy Number | | |
| Who Does the Policy Cover? | | |
| Effective Date of Policy | | |
| Amount of Premium and how often paid? | | |

## HOUSING EXPENSES

Does Your Spouse have a Housing Expense? ☐ Yes ☐ No If Yes, fill in the Requested Information below.

| MONTHLY RENTAL AMOUNT | MONTHLY MORTGAGE AMOUNT | MONTHLY TAX AMOUNT | MONTHLY HEAT BILL |
|---|---|---|---|
| $ | $ | $ | $ |

## RACE/ETHNIC AFFILIATION FOR APPLICANT ONLY

(Completion is optional. However, if not completed, the interviewer may have to record it by observation. This information is being collected only to be sure that everyone receives assistance/care on a fair basis. This information will not affect your eligibility.) I am: (Check Only One)

Race/Ethnic Group Codes: ☐ **B**-Black or African American ☐ **W**-White ☐ **H**-Hispanic or Latino ☐ ***A**-Asian or Pacific Islander ☐ **I**-American Indian or Alaskan Native ☐ ***P**-Native Hawaiian or other Pacific Islander ☐ **U**-Unknown ☐ **O**-Other. ☐

*If you have selected A-Asian, or P-Native Hawaiian or Pacific Islander please see below information on Other AAPI.

†Other Asian American/Pacific Islander (optional) - Please identify your AAPI subgroup. Subgroups within this community include, but are not limited to: Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan, Taiwanese, Native Hawaiian, Samoan, Tongan, Guamanian or Chamorro, Marshallese, Fijian, and other.

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**NON-DISCRIMINATION NOTICE –** This application will be considered without regard to race, color, sex, handicaps, religious creed, national creed, national origin or political beliefs.

**SOCIAL SECURITY NUMBER –** A person making application for Medicaid (MA) shall disclose the Social Security Number of any person for whom Medicaid is requested, except when the individual is an undocumented alien seeking MA-only for the treatment of an emergency medical condition. Such disclosure is mandatory for Medicaid under the authority of Sections 351.2 and 360-1.2 of 18NYCRR and 42 USC 1320b-7. Social Security Numbers are used to provide proper identification of applicants for and recipients of Medicaid and to verify income, eligibility and benefits amounts. We will also be using your Social Security Number to match with IRS unearned income data and with the New York State Department of Labor for earned income data.

**CONSENT –** I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for Medicaid. If additional information is requested, I will provide it.

**CHANGES –** I agree to inform the agency promptly of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

**ASSIGNMENT OF INSURANCE AND OTHER BENEFITS –** I will file any claims for health or accident insurance benefits or any other resources to which I am entitled, and do hereby assign any such resources to the Social Services official to whom this application is made. In addition, I will assist in making any required assignment of benefits or resources to the Social Services official to whom this application is made.

**DIRECT PAYMENT –** I authorize the payment to me or members of my household for health or accident insurance benefits be made directly to the appropriate Social Services official for medical and other health services furnished while we are eligible for Medicaid.

**MEDICARE –** I authorize payments under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medicaid.

**PENALTIES –** I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State Law provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid benefits or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Medicaid or if you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive Medicaid benefits; and such benefits must be used for that other person and not for yourself.

Federal and State Law provide that any transfer of an asset for less than fair market value made by an individual or their spouse within or after the sixty months immediately preceding the first day of the month in which the individual becomes institutionalized, or the date of application for Medicaid as an institutionalized person, if later, may render the individual ineligible for nursing facility services.

**CERTIFICATION –** In signing this application, I swear and affirm that the information I have given or will give to the Department of Social Services as a basis for Medicaid is correct. I also assign to the Department of Social Services any rights I have to pursue support from persons having legal responsibility for my support and to pursue other third-party resources. I understand that upon receipt of Medicaid, a lien may be filed and a recovery may be made against my real property under certain circumstances if I am in a medical institution and not expected to return home. I understand that Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

| | | | |
|---|---|---|---|
| Recipient's Signature | Date Signed | Spouse's Signature | Date Signed |
| Representative's Signature | Date Signed | | |
| Worker's Signature | Date Signed | Supervisor's Signature | Date Signed |