RETHINKING RECERTIFICATION: KEEPING ELIGIBLE INDIVIDUALS ENROLLED IN NEW YORK'S PUBLIC HEALTH INSURANCE PROGRAMS

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FIELD REPORT

August 2003

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

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EXECUTIVE SUMMARY

At least once a year, every Medicaid, Child Health Plus (CHP), and Family Health Plus (FHP) enrollee must recertify his or her eligibility for these public health insurance programs.[1] Through the recertification process, changes in income, family composition, and state of residency are disclosed that may render an individual ineligible and trigger an appropriate disenrollment from Medicaid, FHP, and CHP. However, the recertification requirement also triggers the disenrollment of many eligible individuals who simply fail to complete the process.

New York's recertification process is complex and time-consuming. As a result, the state's public health insurance programs have persistently high levels of involuntary disenrollment each month. Annual disenrollment rates in New York's health programs range from approximately 50 percent for CHP B and Medicaid-only beneficiaries to 85 percent for cash assistance recipients. High rates of involuntary disenrollment persist despite an extraordinary commitment of resources by the state, local governments, health plans, and community-based organizations to facilitate enrollment and recertification in public health insurance programs. Involuntary disenrollment helps keep a large number of New Yorkers uninsured. Despite their eligibility for publicly subsidized coverage, 1.5 million New York State residents, including almost 700,000 children, are eligible for public programs but uninsured.

The central question of our report is whether a stringent recertification process is necessary to prevent significant numbers of families whose income or family size have changed from retaining benefits for which they are not eligible. To answer this question, we studied whether high rates of recertification-driven disenrollment in CHP occur because many enrollees actually become ineligible as their income or family size changes, or whether they reflect administrative burdens that exclude otherwise eligible enrollees. Using survey data and records from CHP insurance plans, we tracked income and family size variation among children recertifying for CHP B, which provides health benefits for children with family incomes above Medicaid limits, up to 250 percent of the federal poverty level.

This study finds that income and family size among CHP B beneficiaries vary little from year to year, and that the vast majority of children due to recertify remain eligible for CHP coverage. Only a small fraction (less than 7 percent) of CHP B beneficiaries are

[1] We use the term "recertification" here even though many states, including New York, have begun to call the review of eligibility the "renewal" process. We continue to use "recertification" because we believe it more accurately describes the process, which requires enrollees to prove their eligibility annually.

ineligible for coverage at the time of recertification based on income and family size. These results indicate that a rigorous recertification process is not justified to ensure that significant numbers of ineligible children do not improperly retain coverage. Furthermore, we found that families that did not complete the recertification process had significantly lower incomes than those that did. This suggests that the complexity of the recertification process has a disproportionate impact on lower-income families—the very families most likely to continue to be eligible for subsidized coverage.

Even though recertification does not screen out significant numbers of ineligible beneficiaries—and actually screens out those who are most needy—New York State, its health plans, and community-based organizations continue to expend significant resources on the burdensome process. It costs nearly $70 in health plan staff costs to recertify each CHP enrollee, plus communication, transportation, printing, postage, and other costs. The state also spends $10 million annually on facilitated enrollment and recertification by community-based organizations. In addition, the recertification process imposes social costs arising out of interruptions in coverage. All of these costs are incurred to screen out ineligible beneficiaries, when the evidence demonstrates that few beneficiaries actually become ineligible a year after enrollment.

This report considers the implications of these findings for reform of the recertification process for all public programs and analyzes the flaws in the piecemeal reforms legislated in New York's Health Care Reform Act of 2002. Given the lack of year-to-year changes in incomes and family size for enrollees and the damaging impact of involuntary disenrollment on New York's insurance coverage rate, dramatic reform of the recertification process across all public health insurance programs is needed. Using models from other states, New York should implement a process that provides for a full eligibility review every other year and a postcard-style short form confirming residency, eligibility, and need for coverage in the alternate years. Further, following the example of other states and its own CHP B program, New York could use existing databases, such as state unemployment tax or IRS databases, rather than requiring enrollees to fill out paperwork to verify eligibility. This proposal would institute a reasonable process for capturing infrequent fluctuations in economic and family circumstances.

RETHINKING RECERTIFICATION: KEEPING ELIGIBLE INDIVIDUALS ENROLLED IN NEW YORK'S PUBLIC HEALTH INSURANCE PROGRAMS

Background

Approximately one-half of the children due to recertify their eligibility for the Child Health Plus B program (CHP B) each month fail to complete the recertification process and are involuntarily disenrolled, accounting for more than 60 percent of all those leaving the CHP B rolls.[2] (For details on CHP A and CHP B eligibility standards, please see the text box on the next page.) These disenrollment rates appear in line with or less than those in other New York public health insurance programs. Although involuntary disenrollment rates for Medicaid have received less scrutiny, the evidence suggests that they are equally high or even higher. According to New York State Department of Health data, more than 85 percent of Medicaid beneficiaries who also receive public assistance fail to complete the recertification process in a typical month.[3] Furthermore, between 1998 and 2000, 12 Medicaid managed care plans, which served 49 percent of New York State's Medicaid managed care beneficiaries, reported losing approximately 4 percent of their membership each month (or 48 percent annually) as a result of involuntary disenrollment.[4]

Researchers and policymakers across the country have identified onerous recertification requirements as a significant barrier to maintaining health coverage among individuals eligible for public programs.[5] According to a national study, if every person with public or private health insurance coverage at the start of a year maintained coverage for even just 12 months, the number of uninsured, low-income children would drop by 40 percent and the number of uninsured, low-income adults would drop by more than 25 percent.[6] Involuntary disenrollment of eligible individuals at recertification is undoubtedly a major contributor to the high number of uninsured in New York. In 2001, 410,000 uninsured children and 870,000 uninsured adults—more than 40 percent of New York's

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[2] Deborah Bachrach and Anthony Tassi, *Coverage Gaps: The Problem of Enrollee Churning in Medicaid and Managed Care and Child Health Plus Plans,* NYS Coalition of Pre-Paid Health Services Plans, December 2000, p. 14; see also A. W. Dick, R. A. Allison, S. G. Haber, C. Brach, and E. Shenkman, "Consequences of States' Policies for SCHIP Disenrollment," *Health Care Financing Review,* Spring 2002, 23(3); Ian Hill and Amy Westpfahl Lutzky, *Is There a Hole in the Bucket?: Understanding SCHIP Retention*, Urban Institute, May 2003.

[3] The disenrollment rate decreases to approximately 65 percent if enrollees who experienced a one- or two-month gap in coverage due to late recertifications are excluded from the count of failed recertifications. A. Tassi and D. Bachrach, *The Medicaid Recertification Assistance Demonstration: Initial Findings and Implications,* Center for Health Care Strategies, December 2001, pp. 7–8.

[4] Bachrach and Tassi, *Coverage Gaps,* p. 8.

[5] Dick et al., p. 66; *Continuing the Progress;* Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families,* The Commonwealth Fund, December 2002, p. 10.

[6] Ku and Cohen Ross, *Staying Covered*.

uninsured—were eligible for health coverage under Medicaid, FHP, or CHP, but not enrolled in these programs.[7]

A Brief Description of New York's Health Programs

New York's **Medicaid** program offers health coverage for families and childless adults eligible for or receiving cash assistance, including very low-income, working families; pregnant women; children; individuals with disabilities; and the elderly. Generally, the income eligibility threshold for single adults (who are neither elderly nor disabled) ranges from 50 to 75 percent of the federal poverty level (FPL), depending on the county of residence and utility expenses. The income threshold for parents of dependent children ranges from 55 to 92 percent of FPL, depending on family size. Pregnant women and infants in families with income up to 200 percent of FPL and children with household income up to 133 percent of FPL may also qualify for Medicaid.

Child Health Plus (CHP) consists of two components, CHP A and CHP B. CHP A is Medicaid for children, while CHP B provides health benefits for children with family income above Medicaid limits, up to 250 percent of FPL.[8] Unlike the Medicaid program, local governments contribute nothing to CHP B funding and have no role in eligibility determinations for CHP B. Instead, eligibility determinations are made by the health plans that participate in the program. The CHP B benefit package, while comprehensive, is more limited than the Medicaid benefit package. For example, long-term care services are not covered and mental health services are subject to annual caps. Unlike Medicaid, benefits are provided only through managed care plans. There is no fee-for-service component.

Family Health Plus (FHP) was established in 2000 as a hybrid of Medicaid and CHP B. It provides coverage for adults with dependent children and childless adults who have income slightly above the Medicaid limits—up to 100 percent of FPL for childless adults and 150 percent of FPL for parents. The program was incorporated into New York's Section 1115 waiver and is funded with Medicaid dollars. Accordingly, local governments pay one-quarter of the costs of FHP and administer the program. FHP provides a more limited benefits package than Medicaid—long-term care services are not available and mental health benefits are capped. Furthermore, FHP offers benefits only through managed care plans. Like CHP B, it has no fee-for-service component.

[7] Danielle Holahan, Marisa Cordova, Kathryn Haslanger, Michael Birnbaum, and Elise Hubert. *Health Insurance Coverage in New York: An Overview and Update,* United Hospital Fund, June 2003, p. 21.

[8] Families with incomes over 250 percent of FPL may purchase CHP B coverage at full cost.

State legislation enacted in January of 2002, the Health Care Reform Act of 2002 (HCRA 2002), mandated that certain aspects of the recertification process in Medicaid, CHP A and B, and FHP be streamlined by April 1, 2003. The legislation and its implementation, however, have maintained the existing disparity between the CHP B recertification process and the far more onerous recertification process for Medicaid (including CHP A and FHP).

Under the HCRA 2002 reforms, Medicaid, FHP, and CHP A enrollees must fill out a 10-page form to recertify outside of New York City and a simpler five-page form within New York City. The CHP B recertification form, not yet implemented as of this writing, is six pages long. HCRA 2002 eliminated the documentation requirement for income at recertification under CHP B, provided that a parent supplies a social security number. Further, the Department of Health, in conjunction with the HCRA 2002 reforms, eliminated the documentation requirements for child care expenses and available health insurance under CHP B, so that only a change in immigration status must be documented at the time of recertification. By contrast, adults recertifying eligibility for Medicaid have to document income, assets (except in New York City), availability of health insurance, child care expenses, and any changes in place of residence or immigration status in order to recertify eligibility for Medicaid.[9] FHP, CHP A, and Medicaid for pregnant women require all these forms of documentation with the exception of asset documentation, since these programs do not impose a limit on assets.

Study Approach

The central question of our report is whether a stringent recertification process is necessary to prevent significant numbers of families from retaining benefits for which they have become ineligible through changes to their incomes or household size. (Household size as such could cause a family to lose eligibility if a family becomes smaller while the family's income remains stable—for example, if a household member dies or moves away.) To answer this question, we studied whether high rates of recertification-driven disenrollment in CHP occur because many enrollees actually become ineligible as their income or family size changes, or whether they reflect administrative burdens that exclude otherwise eligible enrollees. Using survey data and records from CHP insurance plans, we tracked income and family size variation among children recertifying for CHP B.

This report draws on the experience of the 15 health plans in the New York State Coalition of Prepaid Health Services Plans (PHSP Coalition). Coalition plans are

[9] Although HCRA 2002 requires the elimination of the requirement that adults document their assets, as of this writing, only New York City has done so.

sponsored by public and nonprofit hospitals and community health centers, and they provide health care for beneficiaries enrolled in the state's Medicaid managed care, CHP, and FHP programs.[10] The goal of the income data collection and analysis was to document the extent of income fluctuation among a sample group of children enrolled in CHP B in New York City and use this analysis to estimate:

- The percentage of individuals who remain eligible for coverage within a year of enrolling or recertifying.
- The percentage who become ineligible within a year of enrolling or recertifying.

The study relied on data gathered from the three largest plans in the PHSP Coalition, representing 24 percent of total CHP B enrollment in New York City according to the most recently available figures, from December 2002.

Study Methodology

The investigators reviewed enrollment and recertification records for families due to recertify for CHP B coverage during a three-month period in 2001. We documented the extent to which families' income and household composition changed within a year and, to the extent these factors did change, whether the changes were significant enough to render the families ineligible for coverage.

To develop the sample, we first collected data from the three health plans for all children due to recertify for CHP B coverage in June, July, and August of 2001, a total of 6,322 children. The children fell into one of two groups:

- Children who were "successful recertifiers," meaning their families completed the recertification process and were deemed eligible for continued coverage.[11] The "successful recertifier" file comprised 3,056 children.
- Children who "failed to recertify" coverage because they failed to complete the recertification process or submitted recertifications and were not deemed eligible for continued coverage. The "failed to recertify" data file comprised 3,266 children.

[10] These health plans are well positioned to report on the effects of New York's recertification policies, as they serve more than 60 percent of the state's Medicaid managed care beneficiaries, over 50 percent of its CHP beneficiaries, and 49 percent of its FHP beneficiaries. Managed care has rapidly become the delivery system of choice in New York's public health insurance programs. Under a federal waiver, the state has been phasing in mandatory managed care enrollment in its Medicaid program for several years, and managed care is the only option in the CHP and FHP programs. As of early 2003, approximately 1.6 million Medicaid beneficiaries, 500,000 CHP beneficiaries, and 166,000 FHP beneficiaries in New York State are enrolled in managed care plans. (Recipients Eligible for Enrollment in Managed Care: Enrollment Status by Aid Category and County, and Total Percent Enrolled by Provider Plan, NYS Dept. of Health, January 2003.)

[11] We included in this sample one-month "gap" kids, i.e., late recertifiers.

The study then focused on 670 children, including 439 children who were successful in recertifying and 181 children who failed to recertify their coverage (Table 1).

Successful Recertifiers: Project staff constructed a successful recertifier sample of 439 children as follows:

- All children whose families pay premiums for CHP B, a total of 184 records, were retained in the sample. Only one child per family was included in this sample. (Children in households with incomes of 160 percent of FPL or more pay premiums for CHP B coverage.)
- Project staff randomly selected every 10th record to create a "non-premium payer" sample of 255 children.[12] Only one child per family was included in the sample.

Project staff conducted on-site record review at two health plans to collect the following information on successful recertifiers. The third health plan provided an electronic file containing this information:

- 2000 income and family size
- 2001 income and family size
- Immigration status
- Primary language
- Zip code of residence

Project staff collected the above data on 314, or 65 percent, of children in the successful recertifiers sample.

Failed Recertifiers: At the outset of the study, project staff collaborated with the United Hospital Fund (UHF) in creating the failed recertifier sample and collecting income data on this group. Project staff transmitted the complete file of 3,266 children who failed to recertify coverage to UHF. UHF randomly selected 892 records from this file (excluding siblings) and contracted with a private survey firm, Schulman, Ronca & Bucuvalas, Inc., to administer a telephone survey of parents of the failed recertifiers. The survey firm made phone contact (after excluding those with incorrect or inoperable phone numbers) with 453 families. The survey firm completed surveys for the families of 181 children who were "unsuccessful recertifiers," 39.9 percent of those contacted.

[12] The sample size reflected the resources available to the plans and number of investigators available to conduct record reviews.

The survey included questions about health status, service use, satisfaction with care, income, family size, perceived difficulty/ease of the recertification process, and current insurance status. Project staff then collected additional income and household information from the UHF respondents. Specifically, project staff conducted on-site record review at two health plans to collect the following information on the 181 failed recertifiers. The third health plan provided an electronic file containing this information:

- 2000 income and family size
- Primary language
- Zip code of residence

Project staff collected this data on 108, or 60 percent, of children in the failed recertifiers sample. The vast majority—85 percent—of these children had fully subsidized coverage, while 3 percent paid premiums. Plans were unable to report on the premium category for 12 percent of these children.

Table 1. How We Constructed the Sample for the Study

Total Due to Recertify in June–August 2001 in Three Participating Plans N=6,322			
Successful Recertifiers		**Failed Recertifiers**	
All Successful Recertifiers	3,056	All Failed Recertifiers	3,266
Records selected for on-site review (random selection plus all premium payers)	439 (184 premium payers, 255 random)	Randomly selected to participate in phone survey	892
		Contacted	453
Records reviewed	439	Completed phone survey and records reviewed	181 (39.9% of those contacted)
Complete data available from plan records	**314**	**Complete data available from plan records**	**108**
Final Sample—Successful Recertifiers	**314**	**Final Sample—Failed Recertifiers**	**108**

Findings

Our study found that, within the total sample of 422 children due to recertify CHP coverage during the study period, 93 percent remained eligible for CHP coverage in 2001 based on income and family size. Only 2 percent of all families in the sample became ineligible (or would have been deemed ineligible, had they completed the recertification process) for subsidized CHP B coverage in 2001 based on income and/or family size changes. (Due to incomplete data, we were unable to determine the likely outcome of

recertification for 5 percent of the families in the sample.) Not only did the vast majority of families remain eligible for coverage, three-quarters of families in the sample remained in the same income-based premium category in 2001 as in 2000.

Of the families that failed to complete the process, 76 percent would have remained eligible for subsidized CHP had they satisfied all of the administrative requirements. Only 7 percent would have become ineligible. (The remaining 17 percent did not provide sufficient information to determine eligibility.)

Significantly, the study showed that those families that did not complete the recertification process had substantially lower incomes than those that did complete it. Families that did not complete the process had an average income of $14,482 in 2000, while those that completed the process had an average income of $18,950 in 2000. (This difference was significant at the .01 level.) This suggests that the complexity of the recertification process has a disproportionate impact on lower-income families—the very families most likely to continue to be eligible for subsidized coverage.

To summarize, we found that:

- While income and family size among CHP B beneficiaries vary little from year to year, many still fail to fill out and submit recertification paperwork.
- As a whole, the vast majority of 422 children due to recertify during the three-month period remained eligible for CHP coverage, including those who were disenrolled. Most remained eligible in the same premium categories.
- Notably, among families that failed to complete the recertification process, incomes were significantly lower than those that submitted a completed recertification packet.

Discussion and Policy Implications

Recertification Requirements Lead to Arbitrary Loss of Coverage

Our study demonstrates that only the smallest fraction of the many CHP B enrollees who lose coverage at recertification do so justifiably as a result of a change in income or family size. Although the study targeted only CHP B families, this conclusion is likely to apply to CHP A, Medicaid, and FHP, particularly given that these other programs require more extensive documentation, including documentation of income, expenses, and, in some cases, assets in their recertification processes and given that the income levels of their beneficiaries are typically lower than those of CHP B enrollees. Instead of weeding out

significant numbers of ineligible beneficiaries, the recertification process creates gaps in coverage primarily for eligible families, particularly those at the lowest income levels.

The results of our study are corroborated by other research. In a study recently completed by the Urban Institute, only 1 percent of children renewing CHP B coverage in New York were denied coverage for failure to meet eligibility requirements.[13] Further emphasizing the wastefulness of the recertification process, in research carried out together with this study, the United Hospital Fund (UHF) conducted a phone survey of 370 CHP B beneficiaries due to recertify coverage in June, July, or August of 2001.[14] Their sample included 189 CHP beneficiaries who successfully renewed their coverage in addition to the 181 beneficiaries who failed to renew coverage included in our study. UHF performed its survey in June 2002, roughly one year after the targeted renewal date for these beneficiaries. Of the families that had failed to recertify coverage, 66 percent indicated that their child was once again enrolled in CHP as of June 2002. This suggests that administrative issues, rather than eligibility issues, lead to disenrollment at recertification for many children. A recent study supported by the federal Agency for Healthcare Research and Quality has found that nearly a quarter of those children who are disenrolled from the State Children's Health Insurance Programs (CHIP) at recertification return to the rolls within three months.[15]

The Cost of Recertification

New York State and its local governments, as well as the health plans and community-based organizations that participate in its subsidized health insurance programs, dedicate immense resources to the recertification process. Furthermore, burdensome recertification requirements and the high incidence of disenrollment impose substantial social and economic costs.

First and foremost, New York's recertification burden increases the numbers of uninsured by preventing eligible people from staying enrolled in health programs. The loss of insurance often disrupts relationships with the health care practitioners who are familiar with an individual's needs and best able to appropriately manage his or her care. Moreover, when an individual becomes uninsured, he or she often goes without primary and preventive care and delays treatment for chronic or acute conditions until they become emergent.[16]

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[13] Ian Hill and Amy Westpfahl Lutzky, *Is There a Hole in the Bucket?: Understanding SCHIP Retention*, Urban Institute, May 2003.

[14] Michael Birnbaum and Danielle Holahan, *Renewing Coverage in New York's Child Health Plus B Program: Retention Rates and Enrollee Experiences*, United Hospital Fund, 2003.

[15] A. W. Dick et al., *Consequences of States' Policies for SCHIP Disenrollment,* p. 79.

[16] *Care Without Coverage,* Institute of Medicine, 2002.

Second, health plans that participate in CHP and Medicaid managed care must invest substantial resources in the recertification process itself, from mailing out multiple reminders and forms, to following up with phone calls and home visits, to providing assistance with gathering and completing necessary documentation. Three relatively large plans report that they spend almost $70 in staff costs for each enrollee's CHP recertification (Table 2).[17] The average New York City monthly CHP B premium is only $118. In addition to staffing costs, plans incur costs for communication, transportation, printing, postage, office and cellular telephones, copying, two-way pagers, laptops, and portable copying machines. One plan purchased 20 vehicles with global positioning systems at a cost of $24,000 per vehicle to transport recertification staff to the homes and offices of members' parents. Yet, despite their substantial investment in recertification efforts, few plans are able to recertify significantly more than 50 percent of their CHP members. One plan has indicated that in order to properly address its recertification needs, it would have to double the size of its existing recertification staff.

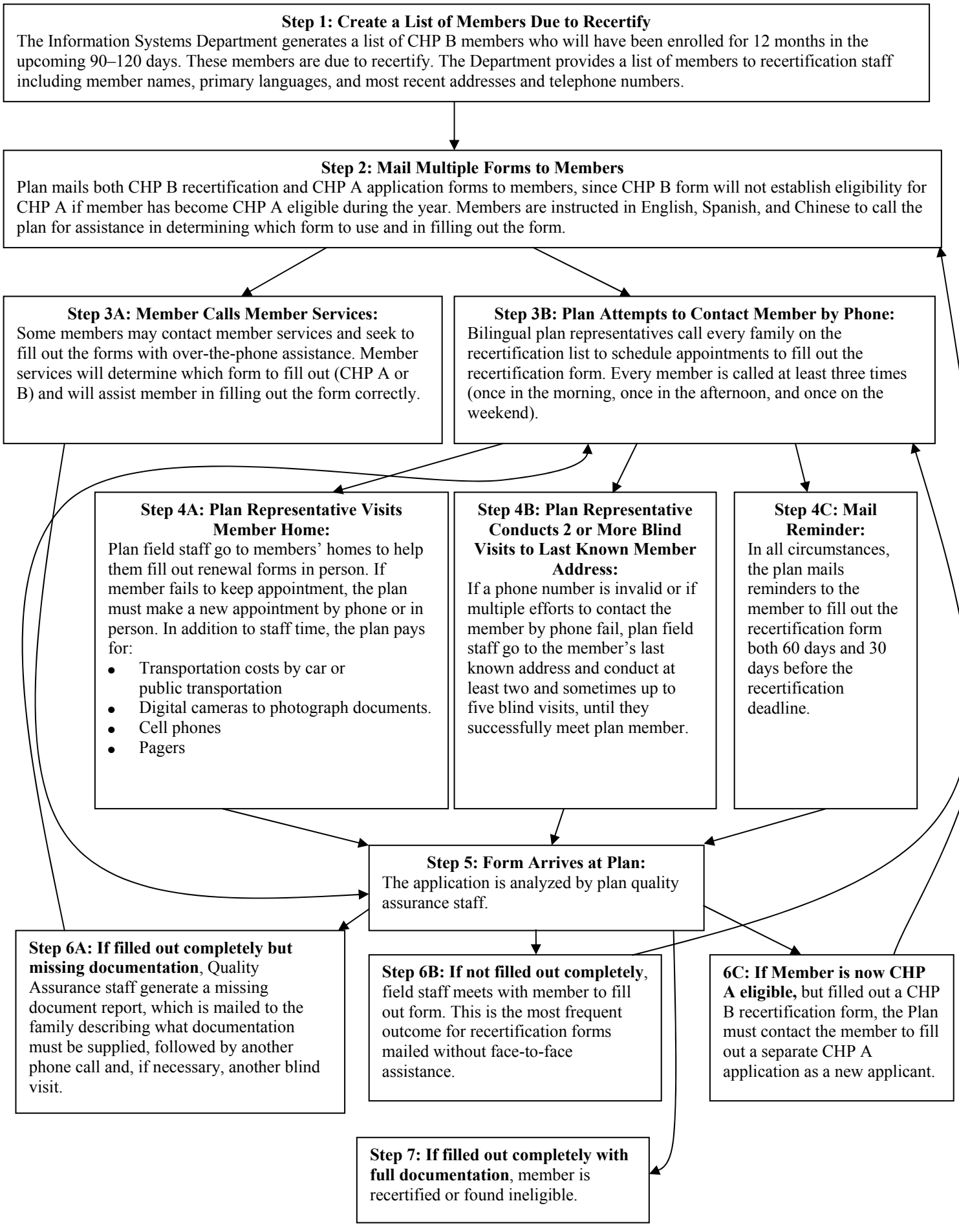
Table 2. Wastefulness of Recertification—Recertification Assistance Is Expensive

- Plans spend an average of almost $70 in staff costs for each CHP enrollee on recertification.
- The need to assist enrollees in person, by mail, and/or by phone imposes significant additional costs. Additional costs include:
  - ✓ vehicle purchases
  - ✓ GPS
  - ✓ fuel
  - ✓ printing
  - ✓ postage
  - ✓ copying
  - ✓ telephones
  - ✓ phone lines
  - ✓ desktop computers
  - ✓ laptops
  - ✓ two-way pagers
  - ✓ cellular phones
  - ✓ digital cameras
  - ✓ digital copiers

The graphic on the next page shows the recertification process followed by one CHP B plan; it is comparable to the process at other plans.

[17] Data available from the PHSP Coalition.

Figure 1. CHP B Recertification



Third, high rates of involuntary disenrollment lead to higher subsequent administrative costs. Health plans must re-enroll members who have lost coverage as new enrollees and therefore must repeat the enrollment process, redistribute materials such as handbooks and identification cards, and repeat the selection of primary care providers for these members. Furthermore, they are prevented from maintaining the membership base they need to cover fixed administrative costs. When Medicaid enrollees cycle in and out of coverage, local districts must send notices terminating coverage, close the cases, then process the applications again, reopen the cases, and send more notices regarding the eligibility determination. All of this otherwise unnecessary activity raises the cost of public health insurance programs. Administrative costs per month drop as the duration of health coverage increases.[18] According to a 2001 study, extending Medicaid coverage for 12 months could lower administrative costs by 2 to 12 percent.[19]

The considerable burden of recertification for public health insurance programs in New York is intensified even further because requirements vary among the Medicaid, FHP, and CHP programs and even among the different Medicaid eligibility categories. As a result of these disparities, individuals within the same household may be forced to recertify their eligibility on different dates, produce different documentation, and submit their applications to different locations. For example, families with income between 133 percent and 150 percent of poverty would likely have parents eligible for FHP, infants eligible for CHP A, and school-age children eligible for CHP B; such families must participate in a different recertification exercise for each family member, potentially on different dates. FHP and Medicaid parents must have documentation for family income, child care expenses, other insurance, and residency. In addition, outside of New York City, FHP parents must attest that they do not have resources in excess of Medicaid limits. Pursuant to HCRA 2002, families of CHP B children are permitted to attest to income (if the parents provide social security numbers), child care expenses, available health insurance, and residency, while families of CHP A children must document all of these factors. Parents are required to fill out as many as three complex forms (if the recertification dates differ for each family member) to maintain coverage for various members of their family. Further complicating this process, any time a family member reaches age 19 or 65, the entire family must immediately recertify its eligibility for Medicaid, even if they had just completed the process only a few months earlier.

New York policymakers have sought to reform the recertification system on an incremental basis. But these reforms have been repeatedly thwarted by the complex and

[18] C. Irvin, D. Peikes, C. Trenholm et al., *Discontinuous Coverage in Medicaid and the Implications for a 12-Month Continuous Coverage for Children,* Mathematica Policy Research, Inc., Cambridge, MA (2001).
[19] Ibid.

disparate eligibility rules and systems that support the programs they have tried to modify. The state's failure to institute more comprehensive reforms to the recertification system means that substantial administrative resources are invested in arbitrarily keeping a large number of eligible Medicaid, FHP, and CHP enrollees from staying in those programs.

Changes to Recertification in New York

The period following the September 11 terrorist attack in New York City demonstrated how much higher health program enrollment could be without the burdensome recertification processes. The attack disabled the city's connection to the state's welfare management system and, at the same time, caused tens of thousands of New Yorkers to lose their jobs and their health insurance. The city and state had to act quickly and decisively to ensure that New York City residents had access to health insurance and health care services. Accordingly, the state and city, with the approval of the federal government, introduced Disaster Relief Medicaid (DRM)—Medicaid with a drastically streamlined enrollment process. They also implemented "automatic" recertification for most Medicaid (including CHP A) and all CHP B beneficiaries, effectively suspending recertification requirements. Retention among Medicaid beneficiaries who had been enrolled prior to September 11 improved dramatically. An analysis of disenrollment rates among eight New York City Prepaid Health Services Plans, with a total Medicaid managed care enrollment of more than 275,000, revealed a decline in the monthly involuntary disenrollment rate from 50 percent annually to 25 percent.[20]

Automatic recertification and DRM led to record growth in Medicaid enrollment in New York City. To maintain these gains, the city and dozens of health plans and community-based organizations took extraordinary steps after DRM ended and recertification was re-instituted, including multiple written and telephone contacts with beneficiaries and a public awareness campaign. Nevertheless, the majority of DRM beneficiaries were ultimately lost to the program when they were required to make the transition from DRM to regular Medicaid. The weight of the Medicaid program's administrative procedures frustrated even an aggressive effort to promote retention of benefits.

[20] Unpublished data available from authors. While the disenrollment rate was cut in half, a quarter of beneficiaries continued to lose coverage. The remaining disenrollment was largely attributable to exceptions to the automatic recertification policy. For example, certain pregnant women receiving Prenatal Care Assistance Program benefits were not entitled to an automatic extension when their coverage terminated 60 days postpartum. Similarly, beneficiaries who were receiving transitional Medicaid coverage after working their way off of welfare were not entitled to an automatic extension of coverage. In addition, some of the involuntary disenrollment may have been caused by the termination of welfare benefits in households receiving both welfare and Medicaid. These individuals and families may have misunderstood the rules and assumed that they did not have to recertify. Instead, they lost coverage. Clearly, even minor inconsistencies within and among programs hindered what were otherwise dramatic changes to the enrollment system.

The Health Care Reform Act of 2002 aimed to preserve at least a portion of the progress achieved through DRM and the automatic recertification process. Specifically, the reforms were intended to streamline those procedures by simplifying recertification forms, removing certain documentation requirements, and eliminating the face-to-face interview at recertification.[21] Most notably, the new CHP B recertification form eliminates many of the questions traditionally found on the Medicaid forms, such as those concerning absent spouses and parents and other sources of payment (see Attachment 1). The CHP B form was developed by a strong public–private partnership, with participation from plans and advocates and support from The Commonwealth Fund. However, because the form eliminates questions and documentation that are still required for Medicaid recertification, it can not be used outside of CHP B.

This creates an added problem for CHP B families who experience a decline in income. Not only does the CHP B form omit certain Medicaid questions, but CHP B eligibility and enrollment information is not reflected in the computer systems used by the county social services agencies that process Medicaid applications. CHP B information is not input into these systems because health plans, rather than social services agencies, handle CHP B eligibility determinations. As a result, families who submit a CHP B recertification form but now qualify for CHP A (because the family has grown or its income has gone down) will lose their coverage altogether unless they fill out a separate CHP A application with all the documentation that the CHP B form eliminated.

Conversely, although New York City managed to develop a radically simplified recertification form for Medicaid, this form cannot be used when families enrolled in Medicaid have become eligible for CHP B at recertification (see Attachment 2). To further complicate the process, the city and state have been unable to consolidate recertification dates when members of the same family are enrolled in different programs. As a result, many families are likely to receive multiple recertification notices at different times with different renewal deadlines.

The new Medicaid recertification form for use outside the city was the most difficult to develop and, in the end, is the least satisfactory (see Attachment 3). In developing the form, the state believed it had to incorporate all questions relevant to each of the Medicaid eligibility categories—from CHP A, to Medicaid for the elderly, blind, and disabled, to Medicaid for families eligible for cash assistance—each with its own eligibility criteria and method of counting income.

[21] 2002 Laws of New York, Chapter 1, Sections 44–54.

In an effort to make significant targeted improvements, the HCRA 2002 reforms were focused on particular barriers to enrollment and recertification and varied by program. Unfortunately, this incremental approach has led to a puzzling hodgepodge of inconsistent requirements among the state's public health insurance programs. Early results of the reformed CHP A/Medicaid recertification process in New York City indicate that there are grounds for concern. Disenrollment rates in early 2003 were as high or higher than before September 11. Whether this is the result of the recertification process or more transitory technical problems in implementing a new system is still unclear as of this writing.

While it is too soon to predict whether these reforms will have the desired effect, the complexity and fragmentation that they have perpetuated has made implementation profoundly challenging. The form developed for CHP B, with almost no documentation requirements, has a great deal of promise. Its impact on involuntary disenrollment may demonstrate how the complexity of the form and required documentation affect continued coverage. But while the CHP B form is itself simple and user-friendly, its use has introduced a new hurdle for families who become eligible for CHP A over the course of a year. The Medicaid/FHP recertification form developed for use outside of New York City under HCRA 2002 maintains the complexity that has previously driven involuntary disenrollment. In another disturbing development, early in 2003 the State Department of Health asked the Legislature to delay, by 12 months, the Department's obligation to eliminate the requirement that beneficiaries document their resources. Although the Legislature rejected this request, as of June 2003 the state had not implemented the mandate to eliminate the asset documentation requirement that was enacted in January 2002 and effective in April 2003.

Conclusion: How to Reduce Disenrollment at Recertification

Given the lack of year-to-year changes in income and family size for enrollees, the magnitude of the resources devoted to recertification assistance, and the damaging impact of involuntary disenrollment on New York's insurance coverage rate, dramatic reform of the recertification process across all public health insurance programs is warranted. Requirements for continued enrollment should be as automated as possible and consistent across all public health insurance programs.

New York should require a full eligibility review via a simplified form every two years. The form recently developed for the CHP B program should be used as a model for Medicaid and FHP. In the alternate years, beneficiaries would be sent previously submitted eligibility information and asked to return a postcard confirming the

information and their continued interest in coverage. New York has already started to use existing government databases to verify eligibility for the CHP B program. Accordingly, it should be well positioned to extend this automated review to Medicaid and FHP. In light of the availability of automated review and the absence of significant variation in income and family size, there is no need for beneficiaries to supply and document income information on an annual basis.

The streamlined renewal procedure proposed for use in alternating years is modeled on the "passive recertification" process that has been adopted by several states in their CHIP or Medicaid programs. In passive recertification, enrollees receive an annual letter with their previous eligibility information and need only reply if there are any changes. Coverage is continued even if no response is received.[22] (See Attachment 4 for Georgia's passive recertification letter for its PeachCare for Kids program.) Passive recertification has the explicit sanction of the federal government under current Medicaid law, as long as states have a mechanism to ensure that beneficiaries continue to reside in the state.[23]

Entirely passive recertification may not be viable in New York State. Rather than making direct payments to physicians, hospitals, and other care providers for health services, the state pays a monthly capitation to managed care plans for most enrollees. Clearly, New York does not want to continue to pay premiums for beneficiaries who no longer reside in the state. Thus, to provide confirmation of residency and other eligibility information in alternate years, we recommend that the state use postcard mailings. If beneficiaries do not return the postcards, managed care plans (or local governments for fee-for-service enrollees) would have a grace period either to remind enrollees to send back their cards or to use medical claims to demonstrate enrollees' continued residency—a mechanism specifically endorsed by the federal government.[24] This approach would combine a form of passive recertification with a version of the highly simplified form New York is beginning to use for its CHP B program.

If the CHP B form were to be expanded for use with Medicaid and FHP, questions not absolutely necessary to prove eligibility, such as the costs of heat and rent and the addresses of absent parents, should be eliminated. As in other states with dramatically streamlined recertification, ongoing audits of a sample of recertifications would monitor the integrity of the eligibility process.

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[22] "Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Centers for Medicare and Medicaid Services, August 2001, Chapter 2.

[23] Ibid.

[24] Ibid.

Burdensome and costly recertification requirements are perpetuating New York State's high uninsured rate. These requirements are not necessary to ensure that the vast majority of public health insurance beneficiaries are eligible for these programs. Policymakers should make the changes to recertification in New York that would bring involuntary disenrollment down to post–September 11 levels or even lower. It is time to adopt a more rational approach. The public's health and the efficient use of public resources demand it.

RELATED PUBLICATIONS

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#662 *New York's HealthPass Purchasing Alliance: Making Coverage Easier for Small Businesses* (August 2003). Stephen N. Rosenberg. This evaluation of HealthPass, New York's health insurance purchasing alliance for small businesses in the city and its suburbs, finds much success to report. The author concludes, however, that HealthPass will not achieve economic self-sufficiency without a partner: a public program that would make HealthPass enrollment more affordable for the many small businesses that cannot now afford to join the program.

#591 *New York Seniors and Prescription Drugs: Seniors Remain at Risk Despite State Efforts—Findings from a 2001 Survey of Seniors in Eight States* (December 2002). David Sandman, Cathy Schoen, Deirdre Downey, Sabrina How, and Dana Gelb Safran. Although New York has one of the nation's largest and most effective prescription drug assistance programs for the elderly, nearly one of five seniors in the state had no coverage for medications in 2001, according to this analysis. As a result of lack of coverage or inadequate benefits, one-fifth of all New York seniors, including one-third of those without drug coverage, reported they skipped doses of medication or did not fill a prescription because of cost concerns.

#574 *Employer Health Coverage in the Empire State: An Uncertain Future* (September 2002). Heidi Whitmore, Kelley Dhont, Jeremy Pickreign, Jon Gabel, David Sandman, and Cathy Schoen. According to this report, the combination of a weak economy, higher unemployment, and rising health care costs is placing pressure on New York State employers to eliminate or scale back health benefits for workers, their dependents, and retirees.

Achieving and Sustaining Improved Quality: Lessons from New York State and Cardiac Surgery (July/August 2002). Mark R. Chassin. *Health Affairs,* vol. 21, no. 4. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845. Available online at http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n4/s8.pdf.

#546 *Health Coverage for Immigrants in New York: An Update on Policy Developments and Next Steps* (July 2002). Deborah Bachrach and Karen Lipson, Kalkines, Arky, Zall & Bernstein LLP. This field report examines the way in which federal welfare reform restricted legal immigrants' access to Medicaid and how a New York State Court of Appeals' decision provides coverage for those previously denied.

#507 *Lessons from a Small Business Health Insurance Demonstration Project* (February 2002). Stephen N. Rosenberg, PricewaterhouseCoopers LLP. This report finds that the recently concluded pilot project, the Small Business Health Insurance Demonstration, launched by New York City in 1997, was successful in providing a comprehensive, low-cost insurance option for firms with two to 50 workers. But poor implementation and marketing, plus flaws in product design, prevented the program from catching on among small businesses.

#485 *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

#484 *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

#473 *Coordinating Care for the Elderly: A Case Study of a Medicaid Long-Term Care Capitation Program in New York* (October 2001). Korbin Liu, Sharon K. Long, Matthew Storeygard, and Amanda Lockshin, The Urban Institute. According to the authors, a New York State demonstration program offering managed care to low-income adults who require long-term care appears to be enrolling more patients than previous programs and offering an expanded range of services.

Accessibility of Primary Care Services in Safety Net Clinics in New York City (August 2001). Eve Weiss, Kathryn Haslanger, and Joel C. Cantor. *American Journal of Public Health,* vol. 91, no. 8. Copies are available from Kathryn Haslanger, United Hospital Fund, 350 Fifth Avenue, 23rd Floor, New York, NY 10118-2399, E-mail: khaslanger@uhfnyc.org.

#458 *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State* (March 2001). Deborah Bachrach, Karen Lipson, and Anthony Tassi, Kalkines, Arky, Zall & Bernstein, LLP. This study of health insurance coverage among New York State's legal immigrants finds that nearly 170,000 low-income adults who would otherwise be eligible for public insurance programs are denied coverage solely because of their immigration status.

Medicaid Managed Care in New York City: Recent Performance and Coming Challenges (March 2001). Derek DeLia, Joel C. Cantor, and David Sandman. *American Journal of Public Health,* vol. 91, no. 3. Copies are available from Derek DeLia, United Hospital Fund, 350 Fifth Avenue, 23rd Floor, New York, NY 10118-2399, E-mail: ddelia@uhfnyc.org.

#444 *Creating a Seamless Health Insurance System for New York's Children* (January 2001). Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant, Children's Defense Fund–New York. New York has recently brought Medicaid and Child Health Plus together, making the two programs more compatible. This paper takes a comprehensive look at both these programs in order to identify areas of continued programmatic disparity and explore ways to bridge differences.

#435 *Emergency Department Use in New York City: A Survey of Bronx Patients* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

#434 *Emergency Department Use: The New York Story* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

#433 *Emergency Department Use in New York City: A Substitute for Primary Care?* (November 2000). John Billings, Nina Parikh, and Tod Mijanovich, New York University. This issue brief, one of three produced from the authors' research, reveals that nearly three-quarters of patients who use New York City hospital emergency departments do so to get treatment for conditions that are either not emergencies or can be treated in a primary care setting.

#378 *Using Community Groups and Student Volunteers to Enroll Uninsured Children in Medicaid and Child Health Plus* (March 2000). Melinda Dutton, Sarah Katz, and Alison Pennington, Children's Defense Fund–New York. In this field report, the authors evaluate two innovative models for enrolling uninsured New York children into Medicaid or Child Health Plus.

#372 *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus* (March 2000). Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc. In this field report, the authors evaluate two innovative models for enrolling uninsured New York children into Medicaid or Child Health Plus.

#369 *Five Boroughs, Common Problems: Health Care in New York City* (February 2000). David Sandman and Elisabeth Simantov. This fact sheet summarizes, by New York City borough, the number of uninsured, the rates of Medicaid coverage, demographic characteristics, and access to health care.

Preventive Service Use and Medicaid Managed Care in New York City (January 2000). Anne Reisinger and Jane Sisk. *American Journal of Managed Care,* vol. 6, no. 1. Copies are available from *American Journal of Managed Care,* American Medical Publishing, 241 Forsgate Drive, Suite 102, Jamesburg, NJ 08831, Phone: 732-656-1006, Fax: 732-656-0818, www.ajmc.com.

#349 *Health Care in New York City: Understanding and Shaping Change* (September 1999). David R. Sandman. This issue brief highlights Fund programs that have been implemented to protect health care access for New York City residents—especially its low-income citizens—in the face of rising uninsurance, the move to mandatory Medicaid managed care enrollment, and the increasing strain on the city's safety net providers and academic health centers.

#340 *A New Opportunity to Provide Health Care Coverage for New York's Low-Income Families* (July 1999). Jocelyn Guyer and Cindy Mann, Center on Budget and Policy Priorities. The authors show how New York could make a substantial dent in its number of uninsured working adults if it took advantage of a little-known legislative opportunity and raised the income eligibility level for subsidized health insurance.

Child Health Plus B

Health Insurance Renewal Form

Child Health Plus

New York State's Health Plan for Kids

Please complete the questions on this form and mail it back using the enclosed envelope. If you do not complete and return this form, your child(ren)'s health care coverage will end. This form can only be used to renew coverage for existing members of Child Health Plus B (CHPlus B) and to evaluate existing CHPlus B members for Medicaid (CHPlus A) eligibility. It cannot be used for adding a new child to these programs. If the children screen eligible for CHPlus A, you may be contacted for additional information. Please see the Instructions at the end for help in completing this form.

If you have questions or need help with this form, or if you would like to add a new child to CHPlus B, contact:

A. About You

Contact information for the person completing this form

First Name	Middle Initial	Last Name	Primary Language

Daytime Phone Where You Can Be Reached	Other Phone Number

Home address of the children renewing health insurance

Street Address			Apartment Number
City	State	ZIP Code	County

Mailing address if different from the home address

Street Address			Apartment Number
City	State	ZIP Code	County

B. About Your Household

List the head of household in the first row of boxes. In the other rows, list the names of all the children in the household who want to continue health insurance coverage. Also list the names of their parents, step-parents, spouses, or children living with them, even if they are not also renewing coverage. You may list other household members, at your option.

Name of Head of Household		Date of Birth (mm/dd/yy)	Pregnant? O Yes O No	Renewing CHPlus B Coverage? O Yes O No	If Yes, provide Social Security number if the child has one.	
Name	Relationship to Head of Household	Date of Birth (mm/dd/yy)	Pregnant? O Yes No	Renewing CHPlus B Coverage? O Yes O No	If Yes, provide Social Security number if the child has one.	01'
Name	Relationship to Head of Household	Date of Birth (mm/dd/yy)	Pregnant? Yes No	Renewing CHPlus B Coverage? Yes No	If Yes, provide Social Security number if the child has one.	02
Name	Relationship to Head of Household	Date of Birth (mm/dd/yy)	Pregnant? O Yes O No	Renewing CHPlus B Coverage? O Yes O No	If Yes, provide Social Security number if the child has one.	03
Name	Relationship to Head of Household	Date of Birth (mm/dd/yy)	Pregnant? O Yes O No	Renewing CHPlus B Coverage? O Yes O No	If Yes, provide Social Security number if the child has one.	04
Name	Relationship to Head of Household	Date of Birth (mm/dd/yy)	Pregnant? O Yes O No	Renewing CHPlus B Coverage? O Yes O No	If Yes, provide Social Security number if the child has one.	05
Name	Relationship to Head of Household	Date of Birth (mm/dd/yy)	Pregnant? O Yes O No	Renewing CHPlus B Coverage? O Yes O No	If Yes, provide Social Security number if the child has one.	06

C03 0 .

C. Household Income

Tell us about everyone listed in Section B who receives income. **If you do not supply a Social Security number for each person, see the attached Instructions for a list of documents you will need to provide as proof of income.**

For each person, indicate how much is received and how often for each type of income. If the person is not regularly employed throughout the year, or if the person's income goes up and down every month, write down the amount the person expects to receive this calendar year.

Use the following defintions for Income Source:

- **Earnings from Work** includes wages, salaries, commissions, tips, overtime, and self-employment.
- **Unearned Income** includes social security benefits, disability payments, unemployment payments, interest and dividends, veteran's benefits, workers compensation, child support/alimony, and rental income.
- **Contributions** includes income from relatives, friends, roomers and boarders (include money that anyone gives to help meet living expenses).
- **Other** income includes temporary (cash) assistance or supplemental security income payments, student grants, or loans.

Name	Social Security Number	(If you don't provide a SSN, you must document your income.)			
Income Source (check and complete all that apply)	**Amount Received**	**How Often?**			
○ Earnings from Work. Name of Employer:	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Unearned Income	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Contributions	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Other	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly

Name	Social Security Number	(If you don't provide a SSN, you must document your income.)			
Income Source (check and complete all that apply)	**Amount Received**	**How Often?**			
○ Earnings from Work. Name of Employer:	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Unearned Income	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Contributions	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Other	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly

Name	Social Security Number	(if you don't provide a SSN, you must document your income.)			
Income Source (check and complete all that apply)	**Amount Received**	**How Often?**			
○ Earnings from Work. Name of Employer:	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Unearned Income	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Contributions	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Other	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly

Name	Social Security Number	(If you don't provide a SSN, you must document your income.)			
Income Source (check and complete all that apply)	**Amount Received**	**How Often?**			
○ Earnings from Work. Name of Employer:	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Unearned Income	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Contributions	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Other	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly

Name	Social Security Number	(If you don't provide a SSN, you must document your income.)			
Income Source (check and complete all that apply)	**Amount Received**	**How Often?**			
○ Earnings from Work. Name of Employer:	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Unearned Income	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Contributions	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly
○ Other	$	○ Weekly	○ Every 2 Weeks	○ Monthly	○ Yearly

No Income: If there is no money coming into the household, explain below how the children renewing coverage are being supported.

Explanation

D. Child/Dependent Care and Other Health Insurance Expenses

Dependent Care: Complete if anyone listed in Section C pays for the care of a child or a disabled adult.

Name of Person Being Cared For	Amount Paid	Frequency
		0 Weekly 0 Every 2 Weeks Monthly
Name of Person Being Cared For	Amount Paid	Frequency
		0 Weekly 0 Every 2 Weeks ~] Monthly
Name of Person Being Cared For	Amount Paid	Frequency
		0 Weekly 0 Every 2 Weeks 0 Monthly

Health Insurance: Complete if anyone listed in Section C pays for health insurance. Do not include CHPlus B premiums paid.

Name of Person Paying	Amount Paid	Frequency
		0 Weekly o Every 2 Weeks 0 Monthly
Name of Person Paying	Amount Paid	Frequency
		0 Weekly o Every 2 Weeks 0 Monthly
Name of Person Paying	Amount Paid	Frequency
		0 Weekly o Every 2 Weeks 0 Monthly

E. Other Changes Since Your Last Application / Renewal

New Health Insurance: Complete for any child listed in Section B who wants to continue coverage and who got new health insurance coverage in the past 12 months. Do not list Medicaid (CHPIus A) or CHPIus B coverage.

Name of Policy Holder	Child(ren) Covered	Insurance Company	Group/Policy Number
Name of Policy Holder	Child(ren) Covered	Insurance Company	Group/Policy Number
Name of Policy Holder	Child(ren) Covered	Insurance Company	Group/Policy Number

Parent or Step-Parent as Public Employee

Is the parent or step-parent of an applying child currently a public employee who can get family coverage through a state health benefits plan?	0 Yes 0 No	If Yes, does the public agency where that person works pay all or part of the cost of this health plan?	0 Yes 0 No

Immigration/Citizenship Status: Complete for any child listed in Section B who wants to continue coverage and whose immigration status changed in the past 12 months. (For example, your child's previous immigration status may have changed from "Legal Permanent Resident" to "Citizen.") Please refer to the Instructions for information on the document(s) you need to include with this form if a renewing child has had a change in immigration status.

Name of Child	What is the new immigration status?
Name of Child	What is the new immigration status?

F. Important Information About Your Rights

You have the option of changing health plans.

If your child is disabled or has a chronic illness, he/she may be eligible for Medicaid (CHPIus A) programs and services.

To receive information about changing health plans or to learn about programs for special needs families, call **1-800-698-4543.**

G. Child Health Plus B Premium

There are no premiums for Medicaid (CHPlus A). There may be a monthly premium for Child Health Plus B. **If you are required to pay a premium, one month's payment must be submitted with this form.** To determine if you need to pay a premium based on your family's monthly income, please see the attached premium chart.

H. Terms, Rights and Responsibilities

By completing and signing this form, I am renewing/applying for Child Health Plus B (CHPlus B) or Medicaid (CHPlus A). I understand that this form, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this form and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this form.

- I understand that I must provide the information needed to prove any eligibility for each program. If I have been unable to get the information for Medicaid, 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 have applied may check the information given by me for 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.
- By applying for CHPlus B, I agree to pay the applicable premium contribution not paid by New York State.
- I understand that CHPlus B and Medicaid will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid, I am giving to the Medicaid agency all of my rights to receive medical support from a spouse or parents of persons under 21 years old and my right to third party payments for the entire time I am on Medicaid.
- 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, or disability status may be a factor in whether or not I am eligible.
- 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.
- SSNs are not required to enroll in CHPlus B. If available, I will include it for children renewing/applying for CHPlus A or B. SSNs are not required for pregnant Medicaid applicants or non-qualified aliens. SSNs are not required of legally responsible adults or any other person residing in the Medicaid applicant's household who is not applying for Medicaid. SSNs are required of legally responsible adults for CHPlus B applicants if documentation of income is not provided. SSNs are required for Medicaid applicants who are not pregnant. 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. The Medicaid agency and the CHPlus Program will use the SSN to verify my income, eligibility, and the amount of medical assistance payments made on my behalf. The information may be matched with the records in other agencies, such as the Social Security Administration, Internal Revenue Service or State Department of Taxation and Finance. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.
- 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 reimbursement for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.
- I consent to the release of any medical information about me and any members of my family for whom I can give consent: (1) by my PCP, any 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; (2) 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, Child Health Plus and Family Health Plus programs; and (3) 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.

1. Signature

I agree to having the information on this application shared only among Child Health Plus B and Medicaid (CHPlus A), my health plans, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Child Health Plus B or Medicaid or to evaluate the success of these programs.

I agree that any licensed doctor, hospital, or other health care provider may give my health plan information about medical services enrolled members of my family have received, as requested, and to such an extent as may be reasonable and necessary for the operation and regulation of the plan. This information will be kept confidential.

By signing this application, I understand that each person renewing/applying for Child Health Plus B or Medicaid (CHPlus A) will be enrolled in the appropriate program, if eligible. I have also read and understand the **Terms, Rights and Responsibilities** included in this form. I certify under penalty of perjury that everything on this form is the truth as best I know.

Signature of Applicant or Representative

Date

X

J. Instructions

Only children under the age of 19 can use this form to renew their CHPlus B health insurance coverage. If you would like to add a new child to CHPlus B, please contact your health plan or facilitated enroller, listed in the letter that came with this form. Please read the entire form and instructions before you fill out the form.

A. About You

This section should be completed by a parent, guardian, or person renewing coverage on behalf of the child(ren).

B. About Your Household

This information helps us determine the size of your family and which program(s) the child(ren) are eligible for. Please list the names of the child(ren) who want to renew their CHPlus B coverage and the names of their parents, step parents, spouses and children, if applicable, living with them. You may also list other household members at your option.

Relationship to Head of Household. List how each person listed in this section is related to the head of household (Examples: child, step-child, spouse).

Renewing CHPlus Coverage. Check "Yes" for each person listed in this section who wants to continue their CHPlus B coverage. Check "No" for household members who are not renewing coverage.

Social Security Number. If the child(ren) renewing CHPlus B coverage have Social Security numbers, they should be provided. Leave this space blank if no Social Security numbers are available for the child(ren) renewing CHPlus B coverage.

C. Household Income

Social Security Number. You have two choices on how you provide your income documentation: 1) You can provide a Social Security number for each individual who receives income for us to check. If you provide a Social Security number, you do not have to provide any documents with this form. 2) Or you can provide proof of income for each type of income listed. The proof must be dated and include the name of the person who gets the income. The list below shows the acceptable documentation for each type of income:

Wages and Salary
- ~ Paycheck stubs (4 consecutive weeks)
- ~ Letter from employer on company letterhead, signed and dated
- ~ Income tax return*
- ~ Business records

Self-Employment
- ~ Signed and dated income tax return and all schedules*

Unemployment Benefits
- ~ Award letter/certificate
- ~ Benefit check
- ~ Correspondence from NYS Dept. of Labor

Social Security
- ~ Award letter/certificate
- ~ Benefit check
- ~ Correspondence from Social Security Administration

Child Support/Alimony
- ~ Letter from person providing support
- ~ Letter from court

Income from Rent or Room/Board
- ~ Letter from roomer, boarder, tenant
- ~ Check stub

Interest/Dividends/Royalties
- ~ Statement from financial institution (i.e., bank)
- ~ Letter from broker
- ~ Letter from agent

Military Pay
- ~ Award letter
- ~ Check stub

Veteran's Benefits
- ~ Award letter
- ~ Benefit check stub
- ~ Correspondence from Veterans Administration

Private Pension/Annuities
- • Statement from pension/annuity

Worker's Compensation
- • Award letter
- • Check stub

Support from Other Family Members
- • Signed statement or letter from family member

*Income tax returns for other than self-employed must be for applications prior to April of the following year

Please note that even if you supply your Social Security number, you may be asked to supply some of the documents above at a later date.

D. Child/Dependent Care and Other Health Insurance Costs

Child Care/Dependent Care Costs. Child care/dependent care costs are how much a parent or other adult in the household pays another person to take care of child(ren) or dependent adult(s) while they are working or going to school. Some of this amount may be subtracted from the household's monthly income and will help us determine for which program the child(ren) are eligible.

Health Insurance Costs. Health Insurance Costs are how much a parent or other adult in the household pays for other health insurance. Do not include CHPlus B premiums paid. We will subtract the cost of health insurance from the household income to determine for which program the child(ren) are eligible.

E. Other Changes Since Your Last Application

New Health Insurance Coverage. It is important to tell us whether any child(ren) who want to renew coverage got new health insurance coverage in the past 12 months because it helps us determine for which program the child(ren) are eligible. It also helps us determine for future medical bills which insurance should pay first.

State Health Benefits Plan means a plan that is offered or organized by the state government on behalf of state employees or other public agency employees within the state. **Public Agency** means any agency of the state, county, city or other type of municipal agency including workers with whom the state contracts. This definition includes public school districts, transportation districts and irrigation districts.

Immigration Status Change. Almost all children who are New York State residents and who do not have other health insurance are eligible for either CHPlus B or Medicaid (CHPlus A), regardless of immigration status. It is important to tell us whether any child(ren) who want to renew coverage had a change in immigration status in the past 12 months because it helps us determine for which program the child(ren) are eligible. An example of a change in immigration status would be if your child was a Legal Permanent Resident but became a Citizen in the past 12 months.

The Immigration and Naturalization Service (INS) has said that enrollment in CHPlus or Medicaid CANNOT affect your child'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 of the information on this form to the INS.**

Proof of Immigration Status Change is only required if the child(ren) are renewing coverage and had a change in immigration status during the past year. Acceptable documentation for proof of immigration status includes the following:

- ~ INS Form 1-551 (Green Card)
- • INS Form I-94
- • INS Form 1-220B
- ~ INS 1-210 Letter
- ~ INS Form 1-181
- ~ Naturalization Certificate
- ~ Other INS documentation or correspondence to or from the INS that shows that the alien is PRUCOL, the alien is living in the U.S. with the knowledge and permission or acquiescence of the INS, and the INS does not contemplate enforcing the alien's departure from the U.S.

F. Important Information About Your Rights

Use this section to request more information about changing health plans, and/or request more information about other Medicaid (CHPlus A) programs and services for which child(ren) in the household might be eligible.

G. Signature

Please sign and date.

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Persc io Obtained Elig I

FOR OFFICE USE ONLY

- Health Plam
- Comm t

L Social Services District L Provider Agency

iicilitated Enrollment Agency. Specify:

T I mp'- °ci b F irn ioorc:

Facilitated EnrollerNam

Lead Agency: Lead Org. ID

Application Start Date: (mm/dd/yy)	Application Sequence Number:	Application Completion Date: (mm/dd/yy)

Enter Code of Applying Child:

Medicaid CHPlus

Child Health Plus B
Premium Chart

New York State's Health Plan for Kids

There are no premiums for Medicaid (CHPlus A). There may be a monthly premium for Child Health Plus B. **If you are required to pay a premium, one month's payment must be submitted with the attached Health Insurance Renewal Form.**

To determine if you need to pay a premium based on your family's monthly income, follow these steps:

1) **Determine family size.** Add up the number of children applying, the number of parents or step-parents living with them, and the number of non-applying siblings under the age of 21 living with them who were listed in Section B.

2) Determine family income. Add up the monthly income for everyone in your family size.

3) Calculate family premium. First locate the table row that shows your family size. Then read to the right to locate which of the four income columns shows the amount of income your family receives per month. Finally, read down that column to the bottom row to determine your premium category. For Family Size of 6 or more, increase the income range by the amount indicated for each additional person.

If you need help understanding your expected CHPlus B premium, call 1-800-698-4543

FAMILY INCOME PER MONTH

FAMILY SIZE	Income below	Income In this **range**	**Income In this range**	Income over
1	$1,197	$1,197 to $1,662	$1,663 to $1,871	$1,871
2	$1,615	$1,615 to $2,243	$2,244 to $2,525	$2,525
3	$2,034	$2,034 to $2,824	$2,825 to $3,180	$3,180
4	$2,453	$2,453 to $3,404	$3,405 to $3,834	$3,834
5	$2,871	$2,871 to $3,985	$3,986 to $4,488	$4,488
6+	+$419	+$581	+$655	
	Free	$9 per child per month (max. $27)	$15 per child per month **(max. $45)**	Full premium: **Contact your health plan**

FAMILY PREMIUM PER MONTH

Effective June 1, 2003. *Income levels* increase *yearly.*
Note: Coverage *for children under* age one is *free at higher* income *levels.*

Medical Assistance Program
Recert Control Unit
GPO Box 2623
New York, NY 10117-1950

MAP-2096F(face)

THE CITY of NEW YORK
Human Resources Administration
Medical Assistance Program

MEDICAID/FAMILY HEALTH PLUS RECERTIFICATION/RENEWAL NOTIFICATION

MARY TURKEY

2424 HOMER RD. #333H
BEARVILLE NY 12700-0000

RESP AREA: CC
LOCATION: CED/FFR
NOTICE DATE: 09/01/2002
CASE NUMBER: 00007419316A
NUMBER OF ADULTS: 03
NUMBER OF CHILDREN: 03
EXPIRATION DATE: 12/31/2002
PRIORITY: N
TELEPHONE NUMBER: 518-383-6969

Dear Consumer:

It is time for us to review your case to see if you can keep getting Medicaid/Family Health Plus. **You do not have to come for an interview. You can now do your recertification/renewal by mail.** Please follow these steps:

1. Look at the mailing address and telephone number above and all the information below, including the address where you live printed on the back page. If something is wrong, write in changes in the blank space.
2. You must send proof of all income. You must also send proof if someone is pregnant, or if someone new is applying or for a change of address, or for new child care expenses. Collect all the proofs that we need.
3. **Sign this form and the "Terms, Rights and Responsibilities" form and mail them along with** all theproofs in the envelope we have sent you. Use the enclosed "Instructions" letter if you have any questions.
4. YOU MUST RESPOND BY 11/01/2002 OR YOUR MEDICAID/FAMILY HEALTH PLUS MAY END.

I.	Household Members		Date of Birth	Sex (M/F)	Social Security Number	Citizenship Status	No Change
01	TURKEY	MARY	04/15/1964	F	NUMBER ON FILE		[ ]
02	TURKEY	JIM	03/15/1965	M	NUMBER ON FILE		[ ]
03	TURKEY	JOE	12/31/1966	M	NUMBER ON FILE		[ ]
04	TURKEY	JOHN	09/01/2001	M	NUMBER ON FILE		[ ]
05	TURKEY	BILL	04/01/2002	M	NUMBER ON FILE		[ ]
06	TURKEY	UNBORN		U			[ ]
07							[ ]
08							[ ]
09							[ ]
10							[ ]
11							[ ]
12							[ ]
13							[ ]
14							[ ]
15							[ ]

In the area above, write in new household members who want to apply and cross out those who have left.

( ) * INDICATES ADDITIONAL HOUSEHOLD MEMBERS ARE ON THE CASE.

II.

Income Type	How Often	Income Amount	No Change
EARNED	MONTHLY	580.70	[ ]
EARNED	MONTHLY	350.00	[ ]

III.

Health Insurance Type	Premium Amount	No Change
		[ ]
		[ ]

IV. Resource Type(s): MULTIPLE Resource Amount : 900.00 No Change [ ]

V. ADDRESS WHERE YOU LIVE:
2424 HOMER RD. #333H No Change [ ]
BEARVILLE NY 12700-0000

Housing/Rent Payment: 625.00 How Often MONTHLY No Change [ ]

VI. Monthly Childcare Expense: How Often: No Change [ ]

VII. Is anyone blind, disabled, handicapped, or has a chronic illness or a special health care need? [ ] Name: No Change [ ]

VIII. Do you have expenses for the care of a disabled adult? [ ] How Much: How Often:

IX. Is anyone pregnant? [ ] Name: Expected Date of Delivery:

X. Does any household member have a spouse or parent who can provide health insurance for them? [ ] If yes, please provide:
Name of spouse or parent:
House Number and Street Name:
City State: Zip Code:
Name of related household member:

XI. Other People in Your Household:
Number of people in household who are NOT applying. (Only count a parent, a stepparent, a spouse of someone applying or children under 21 of someone applying):
None [ ] 1 [ ] 2 [ ] 3 [ ] Other _____

Signature of Applicant or Representative: _____ Date _____

Signature of Spouse (if applying): _____ Date _____

SIGN AND MAIL THIS FORM TO US

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying to renew Medicaid, Family Health Plus, or Child Health Plus A. 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.

- Even if I go to one of the organizations on the List of Facilitated Enrollers for help, it is still my responsibility to make sure the social services district receives the form and proofs by the required date.

- 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, Family Health Plus, and Child Health Plus A 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 Child Health Plus A, 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. I understand that information about me will be submitted to the Immigration and Naturalization Service for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid, Child Health Plus A and Family Health Plus programs.

SOCIAL SECURITY NUMBER: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. 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: If I am enrolled in a Medicaid or Family Health Plus Managed Care Plan, I consent to my Primary Care Provider and any hospital, licensed physician, other health care provider or the New York State Department of Health (SDOH) giving my health plan and any providers in the plan that provide treatment to me and family members for whom I can give consent, any medical information about me/family members that is reasonably necessary to manage my/our care. This information includes HIV or alcohol and substance abuse information about me and/or members of my family for whom I can consent. I know that my consent will expire when my benefits end and the payment process is complete. I know and agree that my health plan and the providers in my health plan can share my medical records and other information regarding treatment provided to me through the plan, such as provider billing records, with SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid and/or Family Health Plus program(s). The signature of each adult joining a health plan is necessary for consent of release of information.

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).

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 application is the truth as best I know.

Signature of Applicant or Representative: _____ Date _____

Signature of Spouse (if applying) : _____ Date _____

MAP-2096J (E-S) reverse
08/19/02

Human Resources Administration
Medical Assistance Programs

FIRME Y MANDE POR CORREO ESTE FORMULARIO

LAS CONDICIONES, DERECHOS Y RESPONSABILIDADES

Completando y firmando esta forma, yo estoy aplicando para renovar Medicaid, Family Health Plus, o Child Health Plus. Yo entiendo que debo proporcionar la información que necesito para demostrar mi elegibilidad para cada programa. Yo estoy de acuerdo en informarle de cualquier cambio a la información en este formulario inmediatamente. Si yo soy incapaz de conseguir la información le diré al distrito de servicios sociales. El distrito de servicios sociales podrá ayudarle a conseguir la información.

- Aun cuando yo vaya a una de las organizaciones en la Lista de Enrollers Facilitados para ayuda, todavía es mi responsabilidad para asegurar que el distrito de servicios sociales reciba el formulario y las pruebas en la fecha requerida.

- Yo entiendo que los obreros de los programas en cual mis familiares o yo estamos renovando pueden verificar la información dada por mi en este formulario. Las agencias que ejecutan estos programas guardarán esta información confidencial según 42 U.S.C. 1396a (a) (7) y 42 CFR 431.300-431.307, y cualquier leyes federales y estatales y regulaciones.

- Yo entiendo que Medicaid, Family Health Plus, y Child Health Plus A no pagarán los gastos médicos que el seguro o otra persona se supone que pague, y que yo le estoy dando a la agencia todos mis derechos para perseguir y recibir el apoyo médico de un esposo o padres de personas bajo 21 años de edad y mi derecho para perseguir y recibir pagos de un tercer partido durante el tiempo completo que yo estoy recibiendo los beneficios. Yo archivaré cualquier demanda de los beneficios de seguro de salud o accidente o cualquier otros recursos que me titulen. Yo entiendo que yo tengo el derecho para exigir la buena causa para no cooperar usando seguro de salud si su uso pudiera causar daño a mi salud o seguridad o a la salud y seguridad de alguien de quien yo soy legalmente responsable.

- Yo entiendo que mi elegibilidad para estos programas no será afectada por mi raza, color, u origen nacional. Yo también entiendo que dependiendo de los requisitos de estos programas individuales, mi edad, sexo, invalidez o estado de ciudadanía pueden ser un factor en si o no yo soy elegible.

- Yo entiendo que si mi niño está en Child Health Plus A, el o ella puede conseguir el cuido primario comprensivo y el cuido preventivo, incluso todo el tratamiento necesario a través del Child Teen Health Program.

- Yo entiendo que cualquiera que a sabiendas mienta o esconda la verdad para recibir los servicios bajo estos programas está cometiendo un crimen y sujeto a las multas federales y estatales y puede tener que reembolsar la cantidad de beneficios recibida y puede pagar multas civiles. El Departamento de Impuestos y Finanzas del Estado de New York tiene el derecho de repasar la información de los ingresos en este formulario.

LA CERTIFICACIÓN DEL ESTATUS DE CIUDADANIA/INMIGRACION: yo certifico bajo la multa de perjurio, firmando mi nombre en esta forma que yo, y o cualquier persona para quien yo estoy firmando es ciudadano americano o nacional de los Estados Unidos o tiene el estado de inmigracion satisfactorio. Yo entiendo que se someterá información sobre mi a los Servicios de Inmigración y Naturalización para la comprobación de mi estado de inmigracion, si aplica. Yo también entiendo que el uso o descubrimiento de información sobre mi será restringida directamente a las personas y organizaciones conectadas con la comprobación de el estado de inmigración y la administración responsable de la entrega de los comestibleses del Medicaid, la Child Health Plus A y los programas de Family Health Plus.

EL NÚMERO DEL SEGURO SOCIAL: Se requieren SSNs para todos los solicitantes, a menos que la persona esta embarazada o sea un fosster o no-calificado. No se requieren SSNs para los miembros de mi hogar que no están solicitando los beneficios. Yo entiendo que esto se requiere por la Ley Federal a 42 U.S.C. 1320b-7 (a) y por las regulaciones de Medicaid a 42 CFR 435.910. Los SSNs se usan de muchas maneras, ambos dentro de la Sección de Servicios Sociales (DSS) y entre el DSS y las agencias federales, estatales y locales, ambas en New York y otras jurisdicciones. Algunos usos de SSNs son para verificar la identidad, identificar y verificar los ingresos ganados de los no ganados, para ver si los padres que no custodian pueden recibir cubertura de seguro de salud para los solicitantes, para ver si los solicitantes pueden conseguir el apoyo médico, y para ver si los solicitantes pueden conseguir dinero u otras ayudas. SSNs también puede ser usados para la identificación del recipiente dentro y adentro de las agencias gubernamentales centrales del Medicaid para asegurarse que los servicios apropiados estén hechos disponibles al recipiente.

EL DESCARGO DE INFORMACIÓN MÉDICA: Si yo me matriculo en un Medicaid o un Family Health Plus Managed Care Plan, yo consiento a mi Proveedor de Cuido Primario y cualquier hospital, médico autorizado, otro proveedor de cuido de salud o el Departamento de Salud el Estado de New York (SDOH) dando mi plan de salud y cualquier proveedor en el plan que proporciona el tratamiento a mi y los familiares para quien yo puedo dar el consentimiento, cualquier información médica sobre mi o mi familia que sea bastante necesario para el manejo del cuido mio o de ellos. Esta información incluye VIH o el abuso mio o de otras personas de la qual yo puedo dar el consentimiento sobre el alcohol o otras substancias. Yo sé que mi consentimiento expirará cuando mis beneficios se acaben y se complete el proceso del pago. Yo sé y estoy de acuerdo que mi plan de salud y los proveedores en mi plan de salud pueden compartir mis archivos médicos y otra información con respecto a tratamiento proporcionado a mi a través del plan, como los archivos de factura del proveedor, con SDOH y otras agencias federales, estatales, y locales que estén autorizadas para los propósitos de administración del Medicaid y/o los Programas de Family Health Plus. La firma de cada adulto que se va a unir a un plan de salud es necesario para el consentimiento del descargo de información.

EL DESCARGO DE ARCHIVOS EDUCATIVOS: Yo doy el permiso a el Departamento de Servicios Sociales Local y al Estado de New York para obtener cualquier información con respecto a los archivos educativos de mis hijos, nombrados aqui dentro, necesario para exigir los reembolsos de Medicaid para los servicios educativos relacionados con la salud, y para mantener el acceso a esta información a la agencia del gobierno federal apropiada para el propósito de auditoria solamente.

EL PROGRAMA DE LA INTERVENCIÓN TEMPRANO: Si mi hijo está evaluado para o participa en el Programa de Intervención Temprano del Estado de New York, yo doy el permiso al Departamento de Servicios Sociales Local y al Estado de New York para compartir la información de elegibilidad del Medicaid de mi hijo con el Programa de la Intervención Temprano de mi condado para el propósito de facturar al Medicaid.

Yo consiento a compartir esta información con cualquier centro de salud basado en la escuela que proporcione los servicios al aplicante.

Firmando esta forma, yo entiendo que cada persona listada se matriculará en el programa apropiado, si es elegible. Yo también he leido y he entendido estas Condiciones, Derechos y Responsabilidades. Yo certifico bajo la multa de perjurio que todo en esta aplicación es la verdad a mi mejor entender.

Firma del Aplicante o Representante: _____ Date: _____

Firma del Esposo o Esposa si También esta aplicando: _____ Fecha: _____

Mail Job 679/680

Instructions — How to Complete Your Form

MAP-2096H (E-S) face
08/16/02

Human Resources Administration
Medical Assistance Programs

If you need help with this letter, call 1-888-692-6116, or call one of the places on the List of Facilitated Enrollers

Si usted necesita ayuda con esta carta, llame al 1-888-692-6116, o llame a cualquiera de los lugares que aparecen en la Lista de Facilitated Enrollers.

Si ou besoin aid avec le't ca, re'le' numero ca a 1-888-692-6116, ou soi re'le' oune dans cote' ca yo qui dans liste de enrolleurs facilitateur ca yo.

Если Вам нужна помощь с этим письмом, позвоните по телефону 1-888-692-6116 или позвоните в одно из мест согласно Списку «Facilitated Enrollers».

如果你需要關于這封信的幫助，請电 1-888-692-6116，或联絡 **Facilitated Enrollers** 已錄上其中的一个地点

INSTRUCTIONS ON HOW TO RECERTIFY/RENEW YOUR MEDICAID/FAMILY HEALTH PLUS

It is time for the Human Resources Administration to see if you can keep getting Medicaid/Family Health Plus (Medicaid includes Child Health Plus A). To keep your health coverage, you must fill out and send in the **"Medicaid/Family Health Plus Recertification/Renewal Notification"** form along with the proofs we ask for. Even if you go to one of the organizations on the List of Facilitated Enrollers for help, it is still your responsibility to make sure we receive the form and proofs by the date shown. **If we do not receive the form and proofs, your Medicaid/Family Health Plus may end.**

To recertify/renew your Medicaid/Family Health Plus:

1. Read the information about your household that is printed on the Notification form and write in any changes. If your address has changed, please send a copy of something with your new address on it.
2. Get all the proofs we ask for. To find out more about proofs, read below and refer to the Documentation Guide.
3. Mail the form, proofs, and the signed "Terms, Rights, and Responsibilities" form to us.

Address

- If you get mail at a different address than where you live, check the mailing address at the top of the form and the address where you live on the back of the form, and make sure both are right.

Section I—Household

Social Security Number

- If the Social Security number column states "Supply Number" for any person, that person must provide their Social Security number.
- If you do not have a Social Security number because of your immigration status, send your most recent letter or paper from the Immigration and Naturalization Service (INS).
- If you are pregnant, you do not need to give us your Social Security number.

Citizenship Status

- For each person with a * in this column, send proof of current citizenship/immigration status.
- If there is a change in citizenship or immigration status for anyone on the form, send the most recent letter or paper from the INS.
- If you are pregnant, you do not need to submit proof of current immigration status.

Adding and Removing a Name

- If you want to add a household member to the case, fill in the information in each column of Section I, send proof of their current citizenship/immigration status, and include their information in every section of the form. If there is not enough space, use a separate paper.
- If you are adding a pregnant woman, you do not need to provide a Social Security number or resources information. If you are adding a person under 19, you do not need to provide resources information.
- If anyone has **left** the household, cross out that person's name.

Section II—Income

List all income of each kind for all members of the household. Send one proof for every kind of income.

- If your last pay-stub is what you usually earn, send a copy of that pay-stub. If your income changes from week to week, send copies of your last four (4) pay-stubs.
- If you do not have pay-stubs, send another kind of proof (like payroll records or a letter from the employer).
- If you cannot get proof because you are paid in cash and your employer will not provide proof, fill out the "Declaration of Income" form.
- If you have no income and someone else supports you, have them fill out the "Declaration of Support" form.
- If you are self-employed, send a copy of your most recent tax return and send a signed statement that your income has not changed or explain how it has changed.

Section III—Other Health Insurance

- If a member of your household has other health insurance, write this information in the "Health Insurance Type" section.
- If you are paying for Medicare Part B, write it here.

Section IV—Resources

- List all current resources (like stocks, bonds, bank accounts, life insurance, and real estate).
- If you are pregnant or under 19, you do not need to list your resources.

Sections VI-IX—Child Care Expenses, Disability, Disabled Adult Care Expenses, and Pregnancy

- Send proof of **any changes** in these sections and identify the people who are new to a category.

Send the signed recertification/renewal form and all proofs in the stamped envelope.

(Vea esta notificacion en Espanol a la vuelta)

Mail Job 679/680

Human Resources Administration
Medical Assistance Programs

If you need help with this letter, call 1-888-692-6116, or call one of the places on the List of Facilitated Enrollers.
Si usted necesita ayuda con esta carta, llame al 1-888-692-6116, o llame a cualquiera de los lugares que aparecen en la Lista de Facilitated Enrollers.
Si ou besoin aid avec le't ca, re'le' numero ca a 1-888-692-6116, ou soi re'le' oune dans cote' ca yo qui dans liste de enrolleurs facilitateur ca yo.
Если Вам нужна помощь с этим письмом, позвоните по телефону 1-888-692-6116 или позвоните в одно из мест согласно Списку «Facilitated Enrollers».
如果你需要關于這封信的幫助，请电 1-888-692-6116，或联络 **Facilitated Enrollers** 目錄上其中的一个地点

INSTRUCCIONES SOBRE CÓMO RECERTIFICAR / RENOVAR SU MEDICAID/FAMILY HEALTH PLUS

Es hora de que la Administración de Recursos Humanos vea si usted puede seguir recibiendo el Medicaid/Family Health Plus (Medicaid incluye el Child Health Plus A). Para mantener su cobertura de salud, usted debe completar y enviar el formulario "**Notificación de Recertificación / Renovación del Medicaid/ Family Health Plus**" junto con las pruebas que le estamos pidiendo. Aun cuando usted vaya a cualquiera de las organizaciones que aparecen en la Lista de Facilitated Enrollers para buscar ayuda, sigue siendo su responsabilidad asegurarse de que recibamos el formulario y las pruebas para la fecha indicada. **Si no recibimos el formulario y las pruebas, su Medicaid/Family Health Plus puede terminarse.**

Para recertificar / renovar su Medicaid/Family Health Plus:

1. Lea la información sobre su hogar que aparece impreso en el formulario de la Notificación y escriba cualquier cambio. Si su dirección ha cambiado, por favor envíe una copia de algo donde aparezca su nueva dirección.
2. Consiga todas las pruebas que le pedimos. Para averiguar más detalles sobre las pruebas, lea debajo y refiérase a la Guía de la Documentación.
3. Envíenos por correo el formulario, las pruebas, y el formulario "Condiciones, Derechos, y Responsabilidades" firmado.

Dirección

- Si usted recibe el correo a una dirección diferente de la que usted vive, verifique la dirección de correos en la parte superior del formulario y la dirección dónde usted vive en la parte de atrás del formulario, y asegúrese que ambos estén correctos.

Sección I—Hogar

El número de seguro social

- Si la columna del número de seguro social dice "Proporcione el Número" para cualquier persona, esa persona debe proporcionar su número de seguro social.
- Si usted no tiene un número de seguro social debido a su estado de inmigración, envíe la más reciente carta o papel recibido del Servicio de Inmigración y Naturalización (SIN).
- Si usted está embarazada, no necesita darnos su número de seguro social.

Estado de Ciudadanía

- Para cada persona con un * en esta columna, envíe prueba del estado de ciudadanía / inmigración actual.
- Si hay algún cambio en la ciudadanía o en el estado de inmigración para cualquier persona en el formulario, envíe la más reciente carta o papel recibido del SIN.
- Si usted está embarazada, no necesita enviar prueba del estado de inmigración actual.

Agregar y Quitar un Nombre

- Si usted quiere agregar a un miembro de su hogar al caso, complete la información en cada columna de la Sección I, envíe prueba del estado de ciudadanía / inmigración actual de dicho miembro, e incluya su información en cada sección del formulario. Si no hay suficiente espacio, use otro papel.
- Si usted está agregando a una mujer embarazada, no necesita proporcionar su número de seguro social ni la información sobre los recursos. Si usted está agregando a una persona menor de 19 años, no necesita proporcionar la información sobre los recursos.
- Si alguien ha abandonado el hogar, tache el nombre de esa persona.

Sección II—Ingresos

Liste todo tipo de ingreso para todos los miembros del hogar. Envíe una prueba para cada tipo de ingreso.

- Si su último talón de pago muestra lo que usted normalmente gana, envíe una copia de ese talón. Si su ingreso cambia de semana a semana, envíe copias de sus últimos cuatro (4) talones.
- Si usted no tiene los talones, envíe otro tipo de prueba (como archivos de nómina o una carta del empleador).
- Si usted no puede conseguir prueba porque se le paga en efectivo y su empleador no proporcionará la prueba, complete el formulario " Declaración de Ingresos".
- Si usted no tiene ningún ingreso y alguien lo mantiene, hágale completar el formulario " Declaración de Sustento".
- Si usted es empleado por cuenta propia, envíe una copia de su más reciente Declaración de Impuestos y envíe una declaración firmada afirmando que su ingreso no ha cambiado o explique cómo ha cambiado.

Sección III—Otro Seguro de Salud

- Si un miembro de su hogar tiene otro seguro de salud, escriba esta información en la sección " Tipo de Seguro de Salud".
- Si usted está pagando Medicaid Part B, escríbalo aquí.

Sección IV—Recursos

- Liste todos los recursos actuales (como las acciones, bonos, cuentas de banco, seguros de vida y bienes raíces).
- Si usted está embarazada o es menor de 19 años, no necesita listar sus recursos.

Secciones VI-IX— Gastos del Cuidado de Niños, Invalidez, Gastos de Cuidado de Adultos Inválidos, y Embarazo

- Envíe prueba de **cualquier cambio** en estas secciones e identifique las personas que son nuevas en alguna categoría.

Envíe el formulario de recertificación / renovación firmado y todas las pruebas en el sobre sellado.

(Turn over to see this notification in English)

MAP-2096A (E-S) face
Rev. 08/16/02

Human Resources Administration
Medical Assistance Programs

DOCUMENTATION GUIDE TO CONTINUE YOUR HEALTH CARE COVERAGE

Here is a list of documents that the Medical Assistance Programs accept. Please review the enclosed "Instructions Letter" to determine what documents you need to provide in order to continue health care coverage.

PROOF OF INCOME: The following documents are proof of income.

Wages and Salary
- Current paycheck/stub(s)
- Letter from employer
- Payroll records

Self Employment
- Signed income tax return and statement
- Records of earnings and expenses

If you cannot get proof of income because you are paid in cash, your employer will not provide proof or other such issue, fill out the **"Declaration of Income"** form. If you have no income, but are being supported by someone else, have the person fill in the **"Declaration of Support"** form.

Unemployment Benefits
- Award Letter/certificate
- Benefit check
- Letter from NYS Department of Labor

Social Security
- Award Letter/certificate
- Benefit check
- Letter from Social Security Administration

Child Support/Alimony
- Letter from person providing support
- Letter from court
- Child support/alimony check stub

Worker's Compensation
- Award Letter
- Check stub

Income from Rent or Room/Board
- Letter from roomer, boarder, tenant
- Check stub

Military Pay
- Award Letter
- Check stub

Veteran's Benefits
- Award Letter
- Benefit check stub
- Letter from Veterans' Administration

Interest/Dividends/Royalties
- Letter from bank or credit union
- Letter from broker
- Letter from agent

Private Pensions/Annuities
- Statement from pension/annuity

CITIZENSHIP OR CURRENT IMMIGRATION STATUS: The following documents are proof of citizenship or immigration status.

- Birth certificate showing U.S. citizenship
- U.S. baptismal certificate
- U.S. passport
- Official U.S. hospital/doctor records
- Naturalization certificate
- Green Card (make copies of both sides because date of entry is sometimes on the back of the card)
- Letter from INS showing status and if necessary, date of entry into the U.S.

RESIDENCY/HOME ADDRESS: The following documents are proof of New York City residency.

- Postmarked envelope, postcard or magazine label with name and date
- ID card with address
- Drivers license issued within past 6 months
- Utility bill (gas, electric, cable), bank statement, or letter from government agency which contains name and home address (not a P.O. Box)
- Letter, lease, rent receipt (with home address) from landlord
- Property tax records or mortgage statement

CHILD CARE/DEPENDENT CARE: The following documents are proof of child care/dependent care expenses. Documents must include the amount you pay and how often.

- Letter from day care center or other child/adult care provider
- Canceled checks or receipts that prove payment of care services

PREGNANCY

- Statement from doctor/medical professional with expected date of delivery

PRIVATE HEALTH INSURANCE: The following documents are proof of private health insurance coverage. Documents must include the amount you pay.

- Insurance policy
- Certificate of insurance
- Insurance card
- Other proof of private insurance

WE ACCEPT PHOTOCOPIES OF ANY DOCUMENT.

(Vea asta notificacion en Espanol a la vuelta)

Mail Job 679/680

Human Resources Administration
Medical Assistance Programs

LA GUÍA DE LA DOCUMENTACIÓN PARA CONTINUAR SU FONDOS DE CUIDADO DE SALUD

Aquí está una lista del los documentos que los Programas de Asistencia Médica aceptan. Por favorec repase " La Carta del las Instrucciones" en el adjuntoel para determinar qué documentos usted necesita para mostrar para continuar los fondos del cuido de salud.

PRUEBA DE INGRESO Los siguientes documentos son prueba del ingreso.

El Sueldo y Salario
- El cheque/talones
- Una carta del patrón
- El archivo de las nóminas

El Empleo-propio
- El retorno del impuesto del ingreso & la declaración firmada
- Los archivos de las gananciases y gastos

Si usted no puede conseguir ninguna prueba de ingreso porque usted le pagan en efectivo,su patron no tiene ninguna prueba que proporcionarle u otro tal problema, rellene la forma de **"Declaración de Ingreso"**. Si usted no tiene ingreso y esta siendo mantenida por otra persona, favor perdirle a esa persona que llene el formulario **"Declaración de Mantenimiento"**.

Los Beneficios del Desempleo
- Carta de premio /certificado
- El cheque de beneficio
- La carta del Deparamento de Labor de NYS

El Seguro Social
- La carta de premio /certificado
- El cheque de beneficio
- La carta del la Administración del seguro social

La Manutención de Niño/Pensión
- La carta de la persona que proporciona el apoyo
- La carta de la corte
- El talon de la pensión

La Compensación del Obrero
- La Carta del premio
- El talón del cheque

El Ingreso de la Renta o Room/Board
- La carta del inquilino, el pensionista, el arrendatario
- El El talón del cheque

Pago Militar
- La Carta del premio
- El talón del cheque

Los Beneficios del Veteranos
- La Carta del premio
- El talón del cheque de beneficio
- La correspondencia de la Admi nistración de Veteranos

Intereses/Dividendos/Derechos
- La carta del banco o unión de crédito
- La carta del corredor
- La carta del agente

Pensiones Privadas/Anualidades
- La declaración de la pension/anualidad

LA CIUDADANÍA O EL ESTADO DE INMIGRACIÓN ACTUAL Los documentos siguientes son prueba de la ciudadanía o del estado inmigración.

- El Certificado de nacimiento mostrando la ciudadanía Americana
- El certificado bautismal Americano
- El pasaporte Americano
- Los archivos oficiales del hospital/doctor Americanos
- El certificado de la naturalización
- La Green Card (haga copias de ambos lados porque la fecha de entrada a veces está en la parte de atrás de la tarjeta)
- La carta de la INS que muestra el estado y si es necesario, la fecha de la entrada a EE.UU.

RESIDENCIA/DIRRECCION DE HOGAR Los documentos siguientes son prueba de la residencia en la Ciudad de Nueva York.

- El sobre marcado con fecha, tarjeta postal o la etiqueta de una revista con el nombre y la fecha
- La tarjetas de ID con la dirección
- La licencia de chóferes emitida dentro los pasados 6 meses
- La factura de las utilidades (el gas, eléctrico, el cable), el estado del las cuentas banquearias,o la carta de la agencia gubernamental que contiene su nombre y dirección de la casa (ningún P.O. Box)
- Una carta, el arriende, el recibo de la renta (con la dirección de la casa) del propietario
- Archivos del impuesto de la propiedad o la declaración de la hipoteca del la

EL CUIDO DEL NIÑO/DEPENDIENTE Los documentos siguientes son pruebas de los gastos del cuido de niño/dependiente. Los documentos deben incluir la cantidad que usted paga y quan a menudo.

- La carta del centro del cuidado diario o de otro proveedor
- Los cheques cancelados o recibos que muestran pago de los servicios de cuido

EL EMBARAZO

- La carta del doctor/professional medico con la esperada fecha de nacimiento

SEGURO DE SALUD PRIVADO Los documentos siguientes son prueba de la cubertura del seguro privado de salud. Los documentos deben incluir la cantidad que usted paga.

- La póliza de seguro
- El certificado del seguro
- La tarjeta del seguro
- Otra prueba de seguro privado

NOSOTROS ACEPTAMOS FOTOCOPIAS DE CUALQUIER DOCUMENTO.

(Turn over to see this Notification in English)

XL0218 (09/97)

NOTICE NUMBER : U0100A3159 Page: 1 *****

ALBANY CO DSS
100 FIRST ST
40 HOWARD ST
ALBANY, NY 12202

NOTICE OF RECERTIFICATION FOR MEDICAL ASSISTANCE.

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA NOTIFICACION EN UN SOBRE APARTE

NOTICE NUMBER:	DATE:	CASE NUMBER:
U0100A3159	March 15, 2003	RAF7

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
CNS	SUCB	CSS02	DEFAULT MA	518-474-9440

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP 518-473-1000

OR Agency Conference 518-473-1000

Fair Hearing information and assistance 518-473-1000

Record Access 518-473-1000

Child/Teen Health Plan 518-473-1000

CASE NAME / AND ADDRESS

CNS/SUCB/CSS02

GINA RAF7
123 TEST ST.
ALBANY, NY 12345

MEDICAL ASSISTANCE

MEDICAID, FAMILY HEALTH PLUS, CHILD HEALTH PLUS A
RENEWAL (RECERTIFICATION) FORM

THIS NOTICE CONTAINS IMPORTANT RENEWAL (RECERTIFICATION) INFORMATION FOR MEDICAID, FAMILY HEALTH PLUS AND/OR CHILD HEALTH PLUS A. FAILURE TO RETURN THIS INFORMATION WILL MEAN YOU WILL LOSE YOUR HEALTH CARE COVERAGE.

Once a year, you or your representative must renew your eligibility for Medicaid, Family Health Plus and/or Child Health Plus A. You must provide the information that follows and return it with certain documentation to the following address by **Tuesday, April 1, 2003:**

OFFICE FOR CNS
1400 BROADWAY

ALBANY NY 12222

You must send proof of your current income, childcare costs, if any, and other changes that have occurred in your household since last year, such as someone started to get other health insurance coverage from an employer. The enclosed "Documentation Checklist" shows you the things you can use as proof of these items. You only need to send proof if the renewal form says you must.

You may call the social services office for help with this form. There are also community organizations and health plans that can help you. You can call 1-877-934-7587 or 1-800-698-4543 to find a health plan or community organization in your area that provides assistance. If you go to one of these organizations for help, bring this letter with you. You must still return the form and documentation to the address above by the date shown. You may wish to keep a copy of this form for your records.

YOU MAY RETURN THIS FORM AND THE DOCUMENTATION BY MAIL OR IN PERSON TO THE SOCIAL SERVICES OFFICE.
YOU DO NOT NEED TO COME IN FOR AN INTERVIEW.

CONTINUED ON THE NEXT PAGE ...

XL0218 (09/97)

NOTICE NUMBER : U0100A3060 Page: 1 *****

ALBANY CO DSS
100 FIRST ST
40 HOWARD ST
ALBANY, NY 12202

NOTICE OF RECERTIFICATION FOR MEDICAL ASSISTANCE.

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA NOTIFICACION EN UN SOBRE APARTE

NOTICE NUMBER:		DATE:	CASE NUMBER:
U0100A3060		March 15, 2003	QUES8ZA
OFFICE: CNS	UNIT: SUCB	WORKER: CSS02	UNIT OR WORKER NAME: DEFAULT MA
			TELEPHONE NO.: 518-474-9440

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP 518-473-1000

OR Agency Conference 518-473-1000

Fair Hearing information and assistance 518-473-1000

Record Access 518-473-1000

Child/Teen Health Plan 518-473-1000

CASE NAME / AND ADDRESS

CNS/SUCB/CSS02

QUES8Z
8 QUESTION 02 EXEMPTION
ALBANY, NY 12203

MEDICAL ASSISTANCE

MEDICAID RENEWAL (RECERTIFICATION) FORM

THIS NOTICE CONTAINS IMPORTANT RENEWAL (RECERTIFICATION) INFORMATION FOR MEDICAID. FAILURE TO RETURN THIS INFORMATION WILL MEAN YOU WILL LOSE YOUR HEALTH CARE COVERAGE.

Once a year, you or your representative must renew your eligibility for Medicaid. You must provide the information that follows and return it with certain documentation to the following address by **Tuesday, April 1, 2003:**

OFFICE FOR CNS
1400 BROADWAY

ALBANY NY 12222

You must send proof of your current income, childcare costs, if any, and other changes that have occurred in your household since last year, such as someone started to get other health insurance coverage from an employer. The enclosed "Documentation Checklist" shows you the things you can use as proof of these items. You only need to send proof if the renewal form says you must.

You may call the social services office for help with this form. The phone numbers are listed above.

You must return the form and documentation to the address above by the date shown.

If you are now receiving Supplemental Security Income (SSI) Benefits, you will continue to receive Medical Assistance for as long as you receive SSI. Please call your worker if you are receiving SSI benefits.

YOU MAY RETURN THIS FORM AND THE DOCUMENTATION BY MAIL OR IN PERSON TO THE SOCIAL SERVICES OFFICE.
YOU DO NOT NEED TO COME IN FOR AN INTERVIEW.

RENEWAL (RECERTIFICATION) FOR MEDICAID - FAMILY HEALTH PLUS - CHILD HEALTH PLUS A

1. You are renewing health care coverage for the following persons (Make any corrections to name or date of birth in the line below). If your Social Security Number is not on file, write it in the space below. If you are pregnant or you do not have a Social Security Number because of your immigration status, you may leave the space blank.

Name	Date of Birth	SSN	Program
GINA RAFT	9/30/1971	Not on File	MA
_____	__/__/____	___-___-____	

(Program codes: MA = Medicaid; FHP = Family Health Plus; CHP A = Children's Medicaid; QMB = Medicare Savings Program)

2. Does everyone listed above still live with you?

[__] Yes.

[__] No. The following people are no longer living with me:

_____

_____

3. a. Does anyone listed above have a spouse, parent/step-parent, or child under 21, living in the household who is not listed above?

[__] No.

[__] Yes.

Name of the spouse, parent/step-parent, or child under 21	Relationship to Head of Household
_____	_____
_____	_____

b. If yes, does this person want to apply for Medicaid/Family Health Plus or Child Health Plus A?

[__] No.

[__] Yes.

(Provide the information below and send proof of the person's date of birth, and citizenship or immigration status. Include this person when you answer the rest of the questions on this form.)

Last Name	First Name	Date of Birth	Sex (M/F)	Social Security Number
_____	_____	__/__/____	___	__/__/____
_____	_____	__/__/____	___	__/__/____

4. Is anyone listed in number 1 or 3 above, pregnant?

[__] No.

[__] Yes. Who? Expected Delivery Date

_____ _____

_____ _____

(See instructions on the documentation checklist.)

CONTINUED ON THE NEXT PAGE ...

5. Has your address changed since you last applied for/renewed your health care coverage?

[__] No.

[__] Yes. My new address is:

House # Street Apt. #

City State ZIP

(You must send proof of new address.)

6. Have your housing expenses changed since you last applied for/renewed your health care coverage?

[__] No.

[__] Yes.

My new monthly housing payment is: $_____

I heat with (gas, oil, electric, etc.): _____

My heat is included in my monthly housing payment: [__] Yes [__] No

7. a. Has the citizenship or immigration status of anyone renewing changed?

[__] No.

[__] Yes. Who?

_____

_____

(You must send proof from the Immigration and Naturalization Service (INS) showing the person's current citizenship/immigration status.)

CONTINUED ON THE NEXT PAGE ...

8. INCOME:

You last reported:

Income Source	How Often	Amount
Salaries, Wages (Employer-Provided Sick Pay)	Mnthly	$700.00

EXPENSES:

You last reported: (We only show those expenses we are allowed to deduct based on the rules for each program.)

Health Insurance Premium	Medicare	Court Ordered Support	Allowable Child/Adult Care
$0.00	$0.00	$0.00	$0.00

What is your income now?
(You must send pay stub(s) or other proof.)

Income Source	How Often	Amount
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

What are your expenses now:
(You must send proof of each expense.)

Health Insurance Premium	Medicare	Court Ordered Support	Child/Adult Care
$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____

CONTINUED ON THE NEXT PAGE ...

****

* The following information is needed to find out about things that may have changed in your household since you last applied for or renewed your Medicaid, Family Health Plus or Child Health Plus A coverage. Give us the information only if it is new or changed. If the answer is no or the situation does not apply to your household, check 'Does not Apply'.

****

9. NEW OR CHANGED HEALTH INSURANCE [__] Does not Apply

a. Since you last applied/renewed, has anyone who had health insurance coverage lost the coverage?

[__] Yes.

Who?	Insurance Company Name	Date Coverage Ended
_____	_____	_____

b. Since you last applied/renewed, has anyone started being covered by health insurance other than Medicaid/Family Health Plus or Child Health Plus A?

[__] Yes.

Who? _____

Premium Amount: $_____ Paid How Often: _____

(You must send a copy of the insurance card or a copy of the insurance policy.)

10. PARENT OR SPOUSE LIVING OUTSIDE THE HOME [__] Does not Apply

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

[__] Yes.

If yes, are you willing to give us information to help you get health insurance from the parent/spouse?

[__] Yes. Give the following information, if known.

Name of parent: _____

Name of spouse: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

Parent/Spouse of: _____

[__] No. If no, is there any reason (good cause) we should not contact this parent/spouse to help you get health insurance? (An example of good cause is that a family member might be harmed in some way.)

[__] No.

[__] Yes. Explain:

_____

_____

CONTINUED ON THE NEXT PAGE ...

b. Since you last applied/renewed, do you have any new information 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 of parent: _____

Name of spouse: _____

Home Address: _____

Work Address: _____

Parent/Spouse of: _____

11. ILLNESS, INJURY OR DISABILITY [__] Does not Apply

a. If you are blind or disabled and must pay special expenses (non-medical) in order to work, CHECK HERE [__]
(You must send in receipts for these expenses.)

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

[__] Yes. Who? _____

Explain: _____

_____

c. Since you last applied/renewed, has anyone had an injury or disability that was caused by someone else, or that could be covered by insurance other than health insurance (such as homeowner's, auto insurance, or Workers' Compensation)?

[__] Yes. Who? _____

Explain: _____

_____

CONTINUED ON THE NEXT PAGE ...

12. RESOURCES

(Note: Pregnant women and child(ren) under the age of 19 do not have to answer this question, unless the person is participating in the Medicaid spenddown program or the child is certified blind or disabled.)

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.)

You last reported:

Resource Type	Value
Bank Accounts	$2,000.00
Trust Funds	$1,500.00

What are your current resources?

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

YOU NEED TO SEND PROOF OF YOUR CURRENT RESOURCES.

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

NOTICE COPIES

Copies of this notice have been sent to the following parties:

LARRY RAPP, 87 SOUTH MANNING BLVD, ALBANY, NY 12203

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying to renew Medicaid, Family Health Plus, or Child Health Plus A.

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, Family Health Plus, and Child Health Plus A 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 Child Health Plus A, 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 Immigration and Naturalization Service (INS) has said that enrollment in Medicaid/Family Health Plus/Child Health Plus A 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 INS.

SOCIAL SECURITY NUMBER SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. 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, Child Health Plus A and Family Health Plus programs; 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 Family Health Plus or 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).

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 application is the truth as best I know.

SIGNATURE of Applicant or Representative _____ DATE _____ SIGNATURE of Spouse (if applying) _____ DATE _____

OFFICE USE ONLY

Worker Signature	Supervisor Signature	Case Disposition

DOCUMENTATION CHECKLIST

This is a list of documents that the Medical Assistance Programs accept. Please review the enclosed "MEDICAID, FAMILY HEALTH PLUS, CHILD HEALTH PLUS A RENEWAL FORM" to determine what documents you need to provide in order to continue your health care coverage. Photocopies are allowed.

PROOF OF INCOME (Everyone renewing must send proof of income.)

Earned Income from Employer	Current paycheck/stubs or letter from employer
Self-Employment Income	Current signed income tax return or record of earnings and expenses
Rental/Roomer-Boarder Income	Letter from roomer, boarder, tenant or check stub
Unemployment Benefits	Award letter/certificate, benefit check, correspondence form NYS Dept. of Labor
Private Pensions/Annuities	Statement from pension/annuity
Social Security	Award letter/certificate, benefit check, correspondence from Social Security Administration
Child Support/Alimony	Letter from person providing support, letter from court, child support/alimony check stub
Worker's Compensation	Award letter, check stub
Veteran's Benefits	Award letter, benefit check stub, correspondence from Veterans Administration
Military Pay	Award letter, check stub
Interest/Dividends/Royalties	Statement from bank, credit union, or financial institution. Letter from broker. Letter from agent
Support from other Family Members	Signed statement or or letter from family member
Income from a trust	Trust document

CITIZENSHIP OR CURRENT IMMIGRATION STATUS **(Must be provided for any new person applying; any person renewing whose status has changed in the past 12 months; or anyone listed in question 7b of the renewal form.)**

U.S. Birth Certificate	U.S. baptismal certificate
U.S. passport	Official U.S. hospital/doctor birth records
Naturalization certificate	INS form I-551 Green Card
INS form I-94, I-210 letter, I220B, or I-181	Other INS documentation or correspondence

RESIDENCY / HOME ADDRESS (Provide only if changed since you last applied/renewed.)

ID card with address	Postmarked envelope, postcard, or magazine label with name and date
Driver's license issued within past 6 months	Utility bill (gas, electric, cable), bank statement, or correspondence from a government agency
Letter/lease/rent receipt with home address from landlord	Property tax records or mortgage statement

CHILD CARE / DEPENDENT CARE EXPENSES (Provide, if applicable.)

Written statement from day care center or other child/adult care provider.

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 Premium statement Insurance Card Termination letter

PREGNANCY

If someone is now pregnant, a statement from a medical provider including the expected date of delivery is required, unless you have already given a statement to us. If you do not have this statement when you return this renewal form, please get it as soon as possible and send it to your worker.

RESOURCES (Family Health Plus recipients, pregnant women and persons under the age of 19 do not need to send proof of resources. Medicaid recipients should refer to question 12 of the renewal form to determine what resources they must prove.)

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 include your home.

Bank statements
Deed or appraisal for Real Estate
Burial agreement
Life Insurance policy
Copies of stocks, bonds, securities
Trust document

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 expense is and who provides it.

[Date]

[Beneficiary Name and Address]

Re: **Renewal Notice For:**
Family Account Number:

PeachCare for Kids looks forward to your continued participation. We are writing to confirm the information on your child(ren)'s record(s) and to verify your monthly payment amount.

We currently have the following on file:

Gross Household Income/Expenses:

Source	Amount	Period	Person	Employer
Current Employer		Yearly		
Current Employer		Yearly		

1st Parent/Guardian: SS#:
Address:
Phone: Work:
2nd Parent/Guardian: SS#:
Address:
Phone:
Emergency Contact:
Phone:

Premium Amount: **Effective November 1, 200_ for December 1, 200_ Coverage.**

Renewal will take place automatically as long as your child(ren) remain eligible and all applicable premiums have been paid. It is not necessary to call us if the above information is correct.

Please remember that you must report any change in your income and circumstances within ten (10) days of becoming aware of change in order to continue to be eligible for PeachCare. To report changes to the information provided in this letter, please contact PeachCare For Kids toll free at 1-877-GA-PEACH (1-877-427-3224).

Please remember, payments are due 30 days in advance. If your payment is late, you may risk cancellation. If your child(ren)'s coverage is cancelled, you will have to pay one month of premium before reinstatement can occur.

You will receive a new payment coupon book within a few weeks. If you have payments due before your payment book arrives, send your payment to this address:

PEACHCARE for Kids Payments
P.O. Box 105864
Atlanta, GA 30348-5846

Thank you for your involvement in your child(ren)'s health.

Sincerely,

PeachCare for Kids