Supplement A

(Supplement to Access NY Health Care Application DOH-4220)

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

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

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

INSTRUCTIONS:

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

A. Applicant and Spouse Information

1. Applicant(s) this Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Marital Status	Social Security Number	Date of Birth	If Deceased, List Date of Death
					/ /	/ /
					/ /	/ /

Is a person named above:

- Chronically ill? ☐ Yes ☐ No
  (Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)
- Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
  (If yes, send proof.)
- Interested in applying for the MBI-WPD program if disabled and working? ☐ Yes ☐ No
  The Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.

If an applicant is living in a long-term care facility/nursing home, adult home, or assisted living facility, provide the following information.

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

If the above previous address was also a facility or adult home, list the address prior to admission below.

Applicant's Second Previous Address	City	State	Zip Code

2. Applicant's Spouse: (if not listed above)

Legal Last Name	Legal First Name	MI
Maiden Name or Other Name Known By:	Social Security Number	Date of Birth / /
Street Address (if in a facility, list spouse's address prior to being admitted to facility)		
City	State	Zip Code

Is the applicant's spouse living in a long-term care facility/nursing home? ☐ Yes ☐ No

If **yes**, provide the following information:

Name of Facility	Date Admitted / /	Telephone Number ( ) -

Street Address	City	State	Zip Code

Is the applicant's spouse deceased? ☐ Yes ☐ No If **yes**, what is the date of death? ____ / ____ / ____

B. What Care and Services are you Applying for? (check the box that applies)

☐ **You are applying for Medicaid coverage but not coverage of community-based long-term care services.** You may attest to the amount of your resources. You are not required to submit documentation of your resources at this time. If a computer match shows something different than what you reported, you may be asked to submit proof at a later date.

This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.*

☐ **You are applying for coverage of community-based long-term care services.** Documentation of the **current** amount of your resources is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

This coverage includes the following services:*

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

Note: Some examples of home and community-based programs that provide waiver and other services are Traumatic Brain Injury Program and Nursing Home Transition and Diversion Program.

☐ **You are institutionalized and applying for coverage of nursing home care.** Documentation of your resources for the **past 60 months** is required. However, you only need to submit documentation for certain resources at this time. See "Documentation Requirements" below for a list of these resources.

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

DOCUMENTATION REQUIREMENTS

If you are requesting coverage for **community-based long-term care services** or **nursing home care,** provide documentation for the time period indicated above for all of the following resources, if applicable.

- Life insurance policy;
- Securities, stocks, bonds, and mutual funds;
- Annuities;
- Burial agreement or fund;
- Trust document and accounts.

You do not need to send proof of any other resources at this time. This is because other resources may be verified through computer matches. If the resources you report do not match our records or cannot be verified through our records, we may ask you to submit proof of those other resources at a later date.

C. Resources/Assets

INSTRUCTIONS FOR SECTIONS 1 THROUGH 8:

- List all resources currently owned by you and/or your spouse/parent(s), including custodial accounts.
- Check the **"NONE"** box if you and/or your spouse/parent(s) do not own any of those resources.
- **If applying for coverage of nursing home care,** also list any accounts CLOSED in the **past 60 months;** include the balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of $2,000 or more.
  Note: Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs): ☐ NONE

Bank Name	Account Number	Name of Owner(s)	Current Account Balance	Closed Accounts	
				Date Closed	Balance at Closing
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$
			$	/ /	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh): ☐ NONE

Institution Name	Account Number	Name of Owner(s)	Pay Out	Current Account Balance	Closed Accounts	
					Date Closed	Balance at Closing
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$
			☐ Yes ☐ No	$	/ /	$

3. Annuities, Stocks, Bonds, Mutual Funds: ☐ NONE

Institution/Company Name	Account Number	Name of Owner(s)	Date Purchased	Current Value	Closed Accounts	
					Date Closed or Sold	Value at Closing
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$
				$	/ /	$

4. Life Insurance Policies: ☐ NONE

Insurance Company	Policy Number	Name of Owner(s)	Current Cash Value	Current Face Value	Cancelled Policies	
					Date Cancelled	Cash Out Value
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$
			$	$	/ /	$

5. Burial Assets/Burial Contracts: (Include copies): ☐ NONE

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

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

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

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

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

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

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

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

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

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

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

6. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the current schedule of trust assets. ☐ NONE

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

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles. ☐ NONE

Name of Owner(s)	Year/Make/Model	Fair Market Value	Amount Owed	In use?	Date Sold
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /
			$	☐ Yes ☐ No	/ /

8. List Any Other Resources:

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

D. Homestead

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

   If **no,** is anyone living in the home? ☐ Yes ☐ No

   Who is living in the home? _____

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

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

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

3. Equity Value in Home:
   If you own your home, what is the equity value in your home? $ _____
   Note: Equity value is the fair market value less any outstanding liens, mortgages, etc.

E. Real Property (other than your home)

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

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

If **yes**, provide the following information:

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

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

F. Asset Transfers

1. Transfers

a. In the last 60 months, did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property? ☐ Yes ☐ No

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

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

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

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

d. In the last 60 months, did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate? ☐ Yes ☐ No

If **yes,** when? _____

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

f. In the last 60 months, did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No

If **yes,** when? _____

g. In the last 60 months, did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No

If **yes,** when? _____

2. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community? ☐ Yes ☐ No

If yes, send copy of agreement.

G. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No

If yes, send complete copies of these returns including all schedules and attachments.

H. Important Information

Liens on Real Property

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

Transfer of Assets

Federal and State laws provide that an individual may be found ineligible for nursing facility services for a period of time if an individual or an individual's spouse transfers an asset for less than fair market value within the look-back period. The look-back period is the 60 months immediately prior to the date an individual is both institutionalized and has applied for Medicaid.

Annuities

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

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse within the look-back period, may be treated as a transfer unless:

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

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

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

I. Certification and Authorization

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

If eligibility depends on the amount of my and my spouse's resources, by signing this application we authorize verification of our resources with financial institutions for the purpose of determining eligibility. Both spouses must sign below. This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Social Services.

X _____
SIGNATURE OF APPLICANT/REPRESENTATIVE

X _____
DATE SIGNED

X _____
SIGNATURE OF APPLICANT'S SPOUSE

X _____
DATE SIGNED