RECERTIFICATION FOR MEDICAL ASSISTANCE (Chronic Care)

NEW YORK STATE — OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

DIRECTIONS

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

LOCAL DISTRICT NAME AND ADDRESS

RECERTIFICATION REFLECTS

- ☐ NO CHANGE
- ☐ CHANGE
- ☐ OUTSTANDING DOCUMENTATION NEEDS

CENTER/ OFFICE	INTERVIEW DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NUMBER	DISTRICT	MA ELIGIBILITY DATES FROM Mo.	FROM Day	FROM Yr.	TO Mo.	TO Day	TO Yr.
				2 0								

CASE NAME	NAME OF INDIVIDUAL INTERVIEWED	CATEGORIES

RECIPIENT'S INFORMATION

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH Mo	Day	Yr.

SEX	SOCIAL SECURITY NUMBER	LIST MAIDEN/OTHER NAMES RECIPIENT HAS BEEN KNOWN BY	ONC
☐ MALE ☐ FEMALE			

NAME AND ADDRESS OF RECIPIENT'S FACILITY

RECIPIENT'S SPOUSE'S INFORMATION

SPOUSE'S FIRST NAME	M.I.	SPOUSE'S LAST NAME	DATE OF BIRTH Mo	Day	Yr.

IF SPOUSE IS DECEASED	IS SPOUSE APPLYING/RECERTIFYING/RECEIVING?	SPOUSE'S SOCIAL SECURITY NUMBER
✓ HERE ☐	☐ YES ☐ NO	

SPOUSE'S ADDRESS	SPOUSE'S PHONE NUMBER Area Code
	( )

LIST ANY OTHER/MAIDEN NAMES BY WHICH YOUR SPOUSE HAS BEEN KNOWN.	ONC

LIST ANY DEPENDENT FAMILY MEMBER WHO IS LIVING WITH YOUR SPOUSE.	FAMILY MEMBER'S SOCIAL SECURITY NUMBER	FAMILY MEMBER'S DATE OF BIRTH Mo	Day	Yr.
LIST ANY FAMILY MEMBER'S RELATIONSHIP TO YOU OR YOUR SPOUSE.				

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

RESOURCES

DO NOT WRITE IN SHADED AREA

LIST ANY RESOURCES THAT THE RECIPIENT MAY HAVE:

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

HAVE YOU OR YOUR SPOUSE SOLD, GIVEN AWAY, OR TRANSFERRED ANY CASH, INCOME, REAL ESTATE, OR OTHER ASSET WITHIN THE PAST 36 MONTHS (60 MONTHS FOR TRUSTS)?

YES	NO	ASSET	VALUE	WHO DID IT GO TO?
			$	
			$	
			$	

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

HEALTH INSURANCE

Does the Recipient Have Medicare (Red, White and Blue Card). ☐Yes ☐No If Yes, Part A ☐ Part B ☐

Does the Recipient's Spouse ☐ or Dependent Family Member ☐ have Medicare? ☐Yes ☐No If Yes, Part A ☐ Part B ☐

Are you, Your Spouse or a Dependent Family Member covered under any Health Insurance Plan, such as Plans provided by Employer, Unions, Retirement System; Coverage under Support Order, Private Insurance Plans or VA *(Aid and Attendance)?* ☐Yes ☐No

Name of Covered Person(s)		
Who Pays the Premium		
Name of Insurance Company		
Policy Number		
Who Does the Policy Cover?		
Effective Date of Policy		
Amount of Premium and how often paid?		

HOUSING EXPENSES

Does Your Spouse have a Housing Expense? If Yes, Fill in the Requested Information. ☐Yes ☐No	MONTHLY RENT AMOUNT	MONTHLY MORTGAGE AMOUNT	MONTHLY TAX AMOUNT	MONTHLY HEAT BILL
	$	$	$	$

RACE/ETHNIC AFFILIATION FOR APPLICANT ONLY

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

B ☐Black not of Hispanic origin W ☐White not of Hispanic origin I ☐American Indian or Alaskan Native

H ☐Hispanic A ☐Asian or Pacific Islander

DO NOT WRITE IN SHADED AREA

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

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

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

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

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

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

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

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

Federal and State Law provide that any transfer of an asset for less than fair market value made by an individual or his/her spouse within or after the thirty-six months (sixty months for transfers to trusts) immediately preceding the first day of the month in which the individual becomes institutionalized, or the date of application for Medical Assistance as an institutionalized person, if later, may render the individual ineligible for nursing facility services.

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

RECIPIENT’S SIGNATURE **X**	DATE SIGNED	SPOUSE’S SIGNATURE **X**	DATE SIGNED
REPRESENTATIVE’S SIGNATURE **X**	DATE SIGNED		
WORKER’S SIGNATURE **X**	DATE SIGNED	SUPERVISOR’S SIGNATURE **X**	DATE SIGNED