This document is being provided in an alternate format (large print, audio or data CD, or Braille) for informational purposes only. Any documents that need to be completed and returned must be completed and returned in written, non-alternative format.

LDSS-4411 (12/99)

NEW YORK STATE
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

RECERTIFICATION FOR MEDICAL ASSISTANCE (Chronic Care)

DIRECTIONS

1. **Please Print Clearly.**
   Do Not Write in the Shaded Areas.
2. Fill out the form completely and accurately.
3. **Sign the Form on the Back Page.**

4. Return this recertification to the address listed.

LOCAL DISTRICT NAME AND ADDRESS ____

RECIPIENT'S INFORMATION

FIRST NAME ____
M.I. ____
LAST NAME ____
DATE OF BIRTH
Mo ____
Day ____
Yr. ____
SEX
☐ MALE
☐ FEMALE
SOCIAL SECURITY NUMBER ____
LIST MAIDEN/OTHER NAMES RECIPIENT HAS BEEN KNOWN BY ____
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 ✓ HERE ☐
IS SPOUSE APPLYING/RECERTIFYING/RECEIVING?
☐ YES
☐ NO
SPOUSE'S SOCIAL SECURITY NUMBER ____
SPOUSE'S ADDRESS ____
SPOUSE'S PHONE NUMBER Area Code ( ) ____
LIST ANY OTHER/MAIDEN NAMES BY WHICH YOUR SPOUSE HAS BEEN KNOWN. ____
LIST ANY DEPENDENT FAMILY MEMBER WHO IS LIVING WITH YOUR SPOUSE. ____
LIST ANY FAMILY MEMBER'S RELATIONSHIP TO YOU OR YOUR SPOUSE. ____
FAMILY MEMBER'S DATE OF BIRTH
Mo ____
Day ____
Yr. ____
PERSON'S PHONE NUMBER Area Code ( ) ____

NAME AND ADDRESS OF PERSON COMPLETING THIS FORM (*If OTHER THAN Recipient or Recipient's Spouse*) ____

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RESOURCES

LIST ANY RESOURCES THAT THE RECIPIENT MAY HAVE:

Personal Incidental Account (PIA)

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Savings Account (Checking/Savings/Certificate of Deposit in Bank, Credit Union)

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____

LOCATION ____

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Expect Lawsuit Settlement, Inheritance

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Trust Fund

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Life Insurance

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Annuity

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Stocks, Bonds, Savings Bonds

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Real Estate (Including Vacation Property and Homestead)

Income-Producing Property

Non-Income-Producing Property

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Own Home
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Mutual Fund
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

IRA, KEOGH, 401-K, Deferred Comp.
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Other Pension or Retirement Account
☐ YES
☐ NO

$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Burial Fund, Burial Trust, Burial Space (Cemetery Plot), Funeral Agreement

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Other Resources (Please Specify)

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Motor Vehicle

☐ YES
☐ NO
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? ____

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

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

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INCOME

LIST ANY INCOME THAT THE RECIPIENT, RECIPIENT'S SPOUSE, OR DEPENDENT FAMILY MEMBER, MAY HAVE:

Social Security/Railroad Retirement

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT ____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT ____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT ____

Pension

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT _____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT _____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT _____

Veteran's Pension

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT _____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT _____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT _____

IRA, KEOGH, 401-K, Deferred Compensation

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT _____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT _____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT _____

Alimony/Spousal Payment

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT _____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT _____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT _____

Mortgage/Rental Income

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT _____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT _____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT _____

Annuity

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT _____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT _____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT _____

Interest from Bank Accounts, Mutual Funds, Stocks, Credit Unit

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT _____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT _____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT _____

Dividends from Stocks, Bonds, Mutual Funds

RECIPIENT'S INCOME

☐ YES

☐ NO

AMOUNT _____

SPOUSE'S INCOME

☐ YES

☐ NO

AMOUNT _____

FAMILY MEMBER'S INCOME

☐ YES

☐ NO

AMOUNT _____

Other Income such as Disability Benefits, SSI, Employment, etc. (*Please Specify*)

RECIPIENT'S INCOME

☐ YES
☐ NO
AMOUNT ____

SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT ____

FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT ____

Do you expect to receive income from a trust, Lawsuit Settlement, Inheritance, etc.?

RECIPIENT'S INCOME
☐ YES
☐ NO
AMOUNT ____

SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT ____

FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT ____

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

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

SOCIAL SECURITY NUMBER—A person making application for 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 ____
DATE SIGNED ____
SPOUSE'S SIGNATURE ____
DATE SIGNED ____
REPRESENTATIVE'S SIGNATURE ____
DATE SIGNED ____
WORKER'S SIGNATURE ____
DATE SIGNED ____