Attachment III

MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding between _____County Department of Social Services (DSS) and _____, (local county health department, publicly supported family planning clinic, or a Prenatal Care Assistance Program (PCAP) provider; hereafter, referred to as the provider) that services _____ County residents in which provider staff accept applications for:

- ❑ Medicaid, Family Health Plus (FHPlus) and Family Planning Benefit Program (FPBP); or
- ❑ FPBP only.

All applications taken at these sites will be forwarded to the local social services district for final eligibility determinations.

Whereas, Social Services Law 366(1)(a)(11) provides reimbursement for family planning services only:

The parties agree as follows:

A. The DSS agrees to:

1. Supply designated provider staff with applications, including:
   _____ the "Family Planning Benefit Program" for applicants who have declined a Medicaid and FHPlus determination;
   _____ the Applicant Release Agreement;
   _____ the "Access NY Health Care" application (DOH-4220) for individuals applying for Medicaid, FHPlus, and FPBP, if this agreement specifies that the provider will accept applications and documents for all covered programs.
2. Supply for distribution to applicants the "Need Help Paying for Medical Care?" brochure (DOH-3360), and "Family Health Plus, New York State's Health Insurance Program for Adults" booklet (DOH-5002).
3. Provide training by district staff to designated provider staff in interviewing techniques and the kinds of information or documents the applicant must provide to verify eligibility.
4. Provide training on the general eligibility requirements for Medicaid, FHPlus and the FPBP.
5. Advise the provider staff of relevant changes in Medicaid regulations and procedures in a timely manner.
6. Follow up on applications after submission by the providers. If the DSS needs additional documentation/verification, it may request that the provider get the information.
7. Notify applicants of the Medicaid/FHPlus or FPBP eligibility decision and forward a copy of the notice to the provider.
8. Give the provider the name(s) of a contact person, a phone number and a fax number, if available, of the contact person at DSS.
9. Cooperate with the provider to establish reasonable procedures to accomplish the tasks described in this document.

B. For the purpose of this program, the Provider will:

1. Designate an interviewer(s) and notify DSS in writing of the name(s), title(s) and qualifications of the person(s) and names of any backup or replacement staff that will be performing eligibility interviews.
2. Notify the DSS in writing of the name(s), title(s) and telephone numbers of the provider staff who will be accepting applications.
3. Retain documentation of the name(s), title(s), and telephone number of staff assisting individuals to complete applications.
4. Obtain a signed Applicant Release Agreement prior to obtaining confidential applicant information.
5. Explain to the applicant the health care programs that may be available to them, specifically Medicaid, FHPlus and FPBP. Provide all applicants the following information: "Need Help Paying for Medical Care?" brochure (DOH-3360), "Family Health Plus, New York State's Health Insurance Program for Adults" booklet (DOH-5002) and the "Health Insurance and Nutrition Access NY Health Care" informational sheet. Designated staff shall review this information with the applicant and help the applicant make an informed choice of applying for all programs or the FPBP only. Advise applicants who want to apply for FPBP only that they may apply for Medicaid or FHPlus at anytime.
6. Provide applicants with the entire application package and assist the applicant in completing the forms as needed.
7. Conduct a face-to-face interview with the applicant or the applicant's representative and obtain as much documentation as possible of all statements on the application form "Access NY Health Care"(DOH-4220) if the applicant is applying for Medicaid, FHPlus and FPBP, or "Family Planning Benefit Program" if the applicant has chosen not to apply for Medicaid or FHPlus. All necessary documentation that is not submitted at the interview must be entered on the Documentation Checklist of the DOH-4220. Provide a copy of the Documentation Checklist to the applicant; notify the applicant of any missing documentation and the due date for submission of documentation. Assist the individual as needed to secure information.
8. Refer any applicant who wants to apply for any other social services program to the DSS office.
9. Provide the original application with the completed Applicant Release Agreement and a photocopy of all documentation required, to DSS on a timely basis using the agreed upon procedures. All completed "Family Planning Benefit Program" applications must include the applicant's signature under the "Declination of Medicaid and Family Health Plus Eligibility Determinations" statement.
10. Maintain a log that shows the applicant's name, date of interview and date on which the application was provided to DSS.
11. Healthcare providers must provide written information to clients on how to access primary care services at Federally Qualified Health Centers (FQHC) and other providers, including their locations and phone numbers.
12. Keep confidential all information obtained while acting as a provider to facilitate the filing of an application.

The unauthorized release of information collected can result in termination of this agreement for violation of the confidentiality requirements cited below and in Section 136 of the Social Services Law and can result in potential legal action. All persons who are designated to take applications and assist applicants as agreed to by the DSS must sign the confidentiality agreement provided by the DSS.

The Medicaid Confidential Data (MCD) includes, but is not limited to, names and addresses of Medicaid applicants/recipients, the medical services provided, social and economic conditions or circumstances, the Department of Health's evaluation of personal information, medical data, including diagnosis and past history of disease and disability, any information regarding income eligibility and amount of Medicaid payment, income information, and/or information regarding the identification of third parties. Each element of Medicaid confidential data is confidential regardless of the document or mode of communication or storage in which it is found.

Note that this Memorandum of Understanding involves Medicaid Data, which is confidential pursuant to New York Medicaid State Plan requirements, 42 U.S.C. Section 1396 a(a)(7) and federal regulations at 42 CFR Sections 431.300 et seq.

Also, pursuant to Section 367b (4) of the New York State Social Services Law, information relating to persons APPLYING FOR Medicaid shall be considered confidential and shall not be disclosed to persons or agencies without the prior written approval of the New York State Department of Health.

AIDS/HIV Related Confidentiality Restrictions:

Also note that MCD may contain HIV related confidential information, as defined in Section 2780 (7) of the New York State Public Health Law. As required by New York Public Health Law Section 2782 (5), the New York State Department of Health hereby provides the following notice:

HIV/AIDS NOTICE

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

The provider agrees that any further disclosure of MCD requires the prior, written approval of the New York State Department of Health (NYSDOH), Medicaid Confidential Data Review Committee (MCDRC). The provider will require and ensure that the approved agreement, contract or document contains the above Notice and a statement that any other party may not disclose the MCD without the prior, written approval of the NYSDOH MCDRC.

Any provider participating in the program who consistently fails to meet minimum performance standards as determined by the DSS may be ineligible to continue as a designated provider to assist individuals in the application process.

The participating provider may withdraw from this program and terminate this Memorandum of Understanding upon 60 days written notice to the DSS. The DSS may terminate this Memorandum of Understanding upon 60 days written notice to the participating provider.

_____	_____
Provider Representative	County Department of Social Services
_____	_____
Title	Title
_____	_____
Date	Date

CONFIDENTIALITY AGREEMENT

I,_____,(title)_____
at or on behalf of the _____ (provider, a local health department, publicly supported family planning clinic, or a Prenatal Care Assistance Program (PCAP)) have been designated to take applications for Medicaid, Family Health Plus (FHPlus), and the Family Planning Benefit Program (FPBP), or for FPBP only, on behalf of the _____County Department of Social Services. I understand that all communications, information, and documents received by me in the course of accepting the Medicaid, FHPlus and FPBP application and assisting the applicant is confidential and may not be disclosed by me to unauthorized personnel or used for any purpose other than determining eligibility for Medicaid, FHPlus and the FPBP.

I have read the attached Confidentiality Statement and understand that any violation of the provisions of this agreement is unlawful and may subject me to loss of my status as a designated interviewer as well as any other penalties prescribed by law.

_____
Signature

_____
Print Full Name

_____
Date

_____
Witness

Confidentiality Statement

Medicaid Confidential Data (MCD) includes, but is not limited to, names and addresses of Medicaid applicants/recipients, the medical services provided, social and economic conditions or circumstances, the Department of Health's evaluation of personal information, medical data, including diagnosis and past history of disease and disability, any information regarding income eligibility and amount of Medicaid payment, income information, and/or information regarding the identification of third parties. Each element of Medicaid confidential data is confidential regardless of the document or mode of communication or storage in which it is found.

Note that this Memorandum of Understanding involves Medicaid Data, which is confidential pursuant to New York Medicaid State Plan requirements, 42 U.S.C Section 1396 a(a) (7) and federal regulations at 42 CFR Sections 431.300 et seq.

Also, pursuant to Section 367b (4) of the New York State Social Services Law, information relating to persons APPLYING FOR Medicaid shall be considered confidential and shall not be disclosed to persons or agencies without the prior written approval of the New York State Department of Health.

AIDS/HIV Related Confidentiality Restrictions

Also note that MCD may contain HIV related confidential information, as defined in Section 2780 (7) of the New York State Public Health Law. As required by New York Public Health Law Section 2782 (5), the New York State Department Of Health hereby provides the following notice:

HIV/AIDS NOTICE

This information has been disclosed to you from confidential records, which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

The providers agree that any further disclosure of MCD requires the prior, written approval of the New York State Department of Health (NYSDOH), Medicaid Confidential Data Review Committee (MCDRC). The Providers will require and ensure that the approved agreement, contract or document contains the above Notice and a statement that any other party may not disclose the MDC without the prior, written approval of the NYSDOH MCDRC.

Applicant Release Agreement

I agree that the information on this application may be shared only with the State Medicaid Program, New York State Family Planning Benefit Program, the local social services districts, and the provider providing the application assistance. I understand that this information is being shared for the purpose of determining my eligibility for Medicaid.

_____ _____

Date Applicant's Signature