Letterhead of Agency or OCFS facility

Attachment

Date: _____

To: _____ County Department of Social Services
Attention: Medicaid Director/Worker (name) _____

Please be advised that (name)_____ is scheduled to be released on _____/_____/_____, from (facility's name) _____. The youth is scheduled to be released to (name) _____ (relationship) _____. The youth, who has been adjudicated as a juvenile delinquent pursuant to Article 3 of the Family Court Act and placed in the custody of the OCFS Commissioner, pursuant to Section 353.3 of the Family Court Act, remains in the custody of the Commissioner and will receive aftercare services from the OCFS (generally for a minimum period of six months).

Check the appropriate box(es) below:

☐ Youth to remain in OCFS Commissioner custody upon release.

☐ The youth named above, **is not currently eligible for Medicaid** because s/he is residing in a Medicaid ineligible setting. The youth is categorically eligible for Medicaid as a household of one upon release from the facility, if s/he is a U.S. citizen or has satisfactory immigration status. Attached is the completed Access NY Health Care application for the youth.

If a social security number is provided for a child who is a U.S. citizen, documentation of citizenship, identity and date of birth are not required at this time. If original documentation was obtained by the OCFS worker, annotated copies indicating that the worker saw the original documents are attached. The worker has also signed and dated the annotated copies. In addition, third party health insurance information has been provided, if known, with required proof of health insurance. Also, absent parent information has been provided, if known and applicable. To expedite the determination of Medicaid eligibility for the youth, the following information has been completed in addition to the information provided in the completed application:

☐The youth may have had Medicaid previously, but requires a new Medicaid CBIC Card.

Date SSN was applied for, if applicable	_____/_____/_____
Proof of satisfactory immigration status if not a U.S. citizen	
Identity Documentation attached (not necessary if SSN included and child is a citizen)	☐Yes ☐No

Discharge Date (if known) _ _ _ _ _ _ _ _ _ or_ _ _ _ _ _ _ _ _ Anticipated Discharge Date	_____/_____/_____ _____/_____/_____
Third Party Health Insurance	☐Yes ☐No ☐Unknown If yes, complete information in Section D of DOH-4220 ☐Copy of insurance card attached
Is child returning to a household with an absent parent?	☐Yes ☐No If yes, complete Section H of DOH-4220

☐ The youth named above, **is currently eligible for Medicaid.** The youth is categorically eligible for Medicaid as a household of one upon release from the facility. Please remove the youth from the facility's roster, update the youth's address on WMS, enter new/revised third party health insurance information (if health insurance information has been provided), and generate a CBIC for the youth if necessary. To expedite this process we are providing the following information:

Client Identification Number	
New Address	
Discharge Date (if known) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Anticipated Discharge Date	_____/_____/_____ _____/_____/_____
Third Party Health Insurance (if available)	☐Yes ☐No ☐Unknown If yes, complete the following and submit a copy of the health insurance card
Insurance Company Name	
Name of Subscriber/Policy Holder	
Group/Policy Number	

Please contact me at the telephone number listed below if you have any questions regarding this letter or the submitted information/documentation.

Name _____ Address _____

Title _____ _____

Phone _____ _____