NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Presumptive Eligibility for Pregnant Individuals Screening

SECTION 1 APPLICANT INFORMATION

Name ______________________ (First) ______ (Middle Initial) ______ (Last Name) Phone Number (______) ______________

Home Address ______ (Street) ______ (Apt. No.) ______ (City) ______ (State) ______ (Zip Code) ______ (County of Residence)

Confidential Address ______ (Street) ______ (Apt. No.) ______ (City) ______ (State) ______ (Zip Code)

Date of Birth ______ (MM DD YYYY) Presumptive Eligibility Determination Date ______ (MM DD YYYY)

Social Security Number ______ (Optional - Please provide if available) EDC ______ (MM DD YYYY)

Citizenship/Immigration Status ☐ U.S. Citizen or Naturalized Citizen ☐ Immigrant Non-Citizen ☐ Not lawfully present
☐ Non-immigrant Visa Holder Date of Status ____/____/____

Sex: ☐ Male ☐ Female ☐ X

Gender Identity (Optional)* ☐ Male ☐ Female ☐ Non-Binary or Non-Conforming ☐ X ☐ Transgender
☐ Different Identity: Describe your Identity in space provided: ______________

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.

SECTION 2 HEALTH INSURANCE

Check if applicant has or has recently (within the last 3 months) applied for ☐ Medicaid ☐ Cash Assistance

If they have applied for either; When? ______ Where? ______ Case Name ______

Does the applicant have any coverage through the NY State of Health? ☐ Yes ☐ No

****The following question about private health insurance can be answered at the option of the pregnant individual.****

Does the applicant have other private health insurance? ☐ Yes ☐ No ☐ I Don't Know

If Yes: ______ (Name of Policy Holder/Subscriber) ______ (Relationship to Policy Holder)

______ (Insurance Company Name) ______ (Group/Policy Number)

Does the applicant need to claim good cause not to bill the above private insurance? ☐ Yes ☐ No

SECTION 3 FAMILY SIZE

Pregnant Individual ____2____

Enter 1 if spouse of applicant is living in household + ______

# of applicant's children (under 21) living in household + ______ = ______ Total Family Size

SECTION 4 INCOME

If applicant is age 21 or older, please enter the gross monthly income for the household. $ ______
(Include wages, Social Security*, unemployment benefits, alimony, etc.)
Gross income is the amount received before taxes or any other deductions are taken.
*Do not include Social Security income received by a dependent child
Do not count: grants, or loans of students, any Temporary Cash Assistance, SSI payments, or child support payments.

SECTION 5 PRESUMPTIVE ELIGIBILITY DETERMINATION

Compare the gross monthly income amount in Section 4 to 223% of the FPL for the applicable family size in Section 3.
If the Gross Monthly Income is: ☐ Less than or equal to 223% of the FPL – Eligible for all Ambulatory Prenatal Medicaid Services
☐ More than 223% of the FPL – Refer to the New York State of Health

If eligible, Health Plan Choice: ______ Doctor: ______

SECTION 6 PROVIDER / SCREENER INFORMATION

Screener Name ______ Screener Signature ______

Qualified Provider Agency Name ______

Address ______ Phone Number (______) ______

INSTRUCTIONS FOR COMPLETING SCREENING FORM -- PLEASE TYPE OR PRINT LEGIBLY

SECTION 1 APPLICANT INFORMATION

Name – List individual's full legal name.
Phone Number – List phone number where individual may receive messages.
Address – List address where individual resides, including zip code. List a mailing address if different from home address.
County of Residence – List county of home address.
Date of Birth – List month, day, and year of individual's birth.
Presumptive Eligibility Determination Date – List date this form is completed and signed. This element is required to begin reimbursement for presumptive coverage.
Social Security Number – SSN is optional.
Citizenship/Immigration Status – Mark the individual's citizenship or immigration status.
EDC – Expected date of confinement or delivery. **This element is required.**

SECTION 2 HEALTH INSURANCE

Ask the pregnant individual if they have recently applied for Medicaid or Temporary Assistance/Cash Assistance. If they applied for Medicaid through the New York State of Health, please check eligibility using the Medicaid verification system available in your office. If they applied through a Local Department of Social Services/Human Resources Administration, you may follow up with the appropriate office.

Ask if they have coverage through the New York State of Health (NYSOH). This could include coverage through Medicaid or qualified health plan (with or without financial assistance like tax credits or cost sharing reductions). If they have coverage through NYSOH, completion of this form is not necessary, advise the individual to update their NYSOH account with their pregnancy information.

The questions about private/employer sponsored health insurance are optional for presumptive eligibility but will be required upon full application. If the individual would like to provide information regarding other health insurance; ask if the coverage is through a private or employer sponsored health insurance plan. If yes, please complete as much information as possible. If the pregnant individual does want Third Party health insurance used, please check the box indicating that the applicant needs to claim good cause not to bill the private insurance. The applicant can claim good cause if the use of the private health insurance could cause harm to her emotional or physical health or safety or the health and safety of someone for whom the applicant is legally responsible.

SECTION 3 FAMILY SIZE

Pregnant individual – count is '2' (individual + unborn)
Spouse – count if legal spouse is living with individual
Children – count individual's children under 21 who live with her
Note: Do not count persons who receive Temporary Cash Assistance or SSI payments

SECTION 4 INCOME

If the pregnant individual is age of 21 or older, enter the gross monthly income for the household. If the pregnant individual is under the age of 21, their income, if any, does not need to be entered.

This is the total gross monthly income for all persons counted in Family Size (Section 3).

Do not include
Income from any person not counted in Family Size (Section 3).
Grants and loans received by students, as well as Temporary Cash Assistance or SSI payments.
Wages may be converted from weekly to monthly by multiplying by 4.333333 or from bi-weekly to monthly by multiplying by 2.166666.

SECTION 5 PRESUMPTIVE ELIGIBILITY DETERMINATION

Compare gross monthly income from Section 4 to the monthly income amount for 223% FPL for the applicable Family Size (Section 3).

If eligible, please indicate the pregnant individual's plan choice and PCP name if known.

SECTION 6 PROVIDER / SCREENER INFORMATION

Enter screener's name, screener's signature, name of Qualified Provider, address and phone number.

Provider's signature is required to authorize Presumptive Eligibility.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Presumptive Eligibility (PE) for Children Screening Form

SECTION 1 APPLICANT'S PERSONAL INFORMATION

Parent/Guardian First Name, Middle Initial, Last Name			Phone Number ( )
Home Address Street Apt. No.	City	Zip Code	County of Residence

PE Determination Date / /	Authorization Approval Number / Name
Application Site	

Child(ren)'s Name(s) (First Name, Middle Initial, Last Name)	**Date of Birth** (MM/DD/YY)	**Sex** M, F, X	**Gender Identity*** (Optional)	**Social Security Number** (Optional)
	/ /			– –
	/ /			– –
	/ /			– –
	/ /			– –

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.
Gender Identity Codes: M-Male, F-Female, N-Non-Binary or Non-Conforming, X-X, T-Transgender, D-Different Identity: Describe your Identity in space provided.

(1) Are all children being screened U.S. Citizens? ☐ Yes ☐ No
(2) If no, are they lawfully present and a NYS resident? ☐ Yes ☐ No
Please list any children who are not U.S. citizens or who are not lawfully present:

If you are not documented, or are a temporary non-immigrant, who is not a NYS resident, you may be able to get Medicaid for the treatment of an emergency medical condition or a pregnancy, if you are determined to be otherwise eligible.

SECTION 2 HEALTH INSURANCE

Do any applying children listed above have or have recently applied for: ☐ **Medicaid** ☐ **Medicare** ☐ **Child Health Plus**

If so, who:_______________________ Place and date of application if not yet in receipt of coverage: ______________

Optional: Do any applying children listed above have other private health insurance? ☐ **Yes** ☐ **No** ☐ **I Don't Know**
If Yes

Name of Policy Holder/Subscriber	Relationship to Child(ren)
Insurance Company Name.	Group/Policy Number
Child(ren) Covered	

SECTION 3 FAMILY SIZE

Enter # of parent(s) of applying children who are living in the household _______

Enter 1 if child is not living with a parent but with a caretaker relative who will also be applying for MA (i.e. grandparent, aunt, uncle, adult sibling, etc.) _______

Enter # of children who live in applying child(ren)'s household who are under age 21, including applying child + _______

Total # in Household = _______

SECTION 4 INCOME

Household's **total monthly gross** income (Before taxes and any deductions) $ ______

(Include, wages, tips, commissions, Social Security*, alimony, unemployment benefits, etc.)

Do not include child support payments, grants or loans of students, or any Temporary Cash Assistance or SSI payments.

**Do not include Social Security income received by a dependent child.*

SECTION 5 PRESUMPTIVE ELIGIBILITY DETERMINATION

Compare the household's gross monthly income amount in Section 4 to current monthly income levels for the Family Size in Section 3.
If gross monthly income is less than or equal to 154% of the FPL – Children age 1 through 18
☐ Yes – Presumptively Eligible; List Name(s):
☐ No – Not Presumptively Eligible; List Name(s):

If gross monthly income is less than or equal to 223% of the FPL – Infant under age 1
☐ Yes – Presumptively Eligible; List Name(s):
☐ No – Not Presumptively Eligible; List Name(s):

☐ Ineligible for anything other than the treatment of an emergency medical condition; cannot have presumptive eligibility; List Name(s):

Make referral to State Child Health Plus Program (see information below)

SECTION 6 ENTITY / SCREENER INFORMATION

Screener Name	Screener Signature
Qualified Entity Agency Name	
Address	Phone Number ( )

If ELIGIBLE, submit to Department of Social Services within 21 days.
If INELIGIBLE, make referral to NY State of Health or call 1-800-698-4KIDS (1-855-355-5777).

INSTRUCTIONS FOR COMPLETING SCREENING FORM

PLEASE TYPE OR PRINT LEGIBLY

Section 1 – Applicant's Personal Information	**Name:** List name of parent(s)/guardian(s) of the applying child(ren) **Phone Number:** Enter contact/message number **Address:** List the address where the child(ren) live(s) including house number, street name, apt number, city, and zip code **County of Residence:** Enter the county in which above address is located or NYC if a New York City resident **PE Determination Date:** List today's date **Application Site:** List the name of the Qualified Entity Site **Authorization Number/Name:** Call NYSDOH – 1-888-375-1912 to obtain authorization number for children who determined presumptively eligible. Document the name of the person who provided you with the number. **Child(ren)'s Name(s):** List all children who are being screened for PE for Children **DOB:** List month, day, and year of child(ren)'s birth **Sex:** Indicate the appropriate sex in this space **Social Security Number:** Enter SSN (optional). Note: SSN or proof of application for SSN will have to be provided for full Medicaid determination. **Citizenship/Immigration Status:** (1)/(2)Check boxes as appropriate. Explain that Medicaid is available to people who are US Citizens or are lawfully present and a NYS resident. Others may receive treatment only for an emergency medical condition or a pregnancy. If unsure of the child(ren)'s status, ask if they have any of the following: a Green Card, a Passport, a Visa or any other immigration document. Also, ask if they are working with immigration services to get permanent status.
Section 2 – Health Insurance	Complete as much information as known. Inquire about recent applications for Medicaid and Child Health Plus. If yes, indicate when and where the application was taken. Information about private health insurance is optional for PE screening but will be required upon application for full coverage.
Section 3 – Family Size	Enter numbers to identify number of persons living in the household. If the parent of the applying child is pregnant, count as 2 (parent plus the unborn child). Count the legal spouse and/or other parent of the child, if they live in the household. Count 1 for Caretaker Relative (if no parents live in the household) and if they will also be applying for Medicaid. Count all of the children under age 21 in the household whether or not they are applying. Do not count persons who receive Temporary Cash Assistance or SSI cash assistance.
Section 4 – Income	Enter the total amount of the monthly gross (before taxes and deductions) household income. Verification is not required for PE. Weekly wages are converted to monthly by multiplying by 4.3333. Do not count grants or loans of students, Temporary Cash Assistance or SSI Case Assistance. Do not include Social Security income received by a dependent child. Enter caretaker relative's income if they are in the household count and are applying for MA.
Section 5 – Presumptive Eligibility Determination	Compare the gross monthly income with the income standards chart for the appropriate household size calculated in Section 3 and percentage of the Federal Poverty Level for the age of each child. If the child(ren) is found to be eligible, the corresponding box(es) is checked, the child(ren)'s name(s) listed and a Presumptive Eligibility Screening Determination letter is given to the applying parent or guardian with the names of the children who are Presumptively Eligible for Medicaid. This letter advises households of next steps to take to apply for ongoing Medicaid. This completed screening form, an accompanying Medicaid application, determination letter and all documentation are forwarded to the appropriate county Local Department of Social Services (LDSS) within 21 days for further review and a determination for ongoing Medicaid. If any child applying is ineligible, list the name of the child(ren) who is ineligible and refer to the phone numbers at the bottom of the screening form for information on applying for Child Health Plus, and/or refer to the nearest Navigator for application assistance. If all children on the screening are ineligible, do not send the PE screening form to the LDSS, but retain copies in a locked, secure area.
Section 6 – Entity/Screener Information	Enter screener's, screener's signature, name of Qualified Entity, address and phone number. **Screener's signature is required to authorize Presumptive Eligibility.**

If ELIGIBLE, submit to Department of Social Services within 21 days.
If INELIGIBLE, make referral to State Child Health Plus Program. Call 1-800-698-4KIDS (1-800-698-4543).

Medicaid Presumptive Eligibility (PE) for the Family Planning Benefit Program (FPBP) Provider Screening Form

1. APPLICANT'S PERSONAL INFORMATION

a. Applicant's Legal Name: ______________________________
First Name Middle Initial Last Name

b. Legal Residential Address: ______________________________
Street Apt. # City Zip Code

County of Legal Residence: ______________________ Resident of New York City (NYC) ☐ Yes ☐ No

Is it OK for us to send a Family Planning Benefit Program benefit card and related mail to your residential address? ☐ Yes ☐ No

If not, please provide us with a confidential mailing address below:

Confidential Mailing Address: ______________________________
Street Apt. # City Zip Code

c. Home Telephone Number: (________)____________–________________

Is it OK for you to get calls related to your application at this number? If not, please provide us with a confidential contact number where you can receive calls related to your application below:

Confidential Phone Number: (________)____________–________________

d. Social Security Number (optional): ________ – ________ – ____________

e. Date of Birth: ________ / ________ /____________
MM DD YYYY

g. Sex: ☐ Female ☐ Male ☐ X

f. Gender Identity (Optional)* (See codes below): ________________

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.
Gender Identity Codes: M-Male, F-Female, N-Non-Binary or Non-Conforming, X-X, T-Transgender, D-Different Identity: Describe your Identity in space provided.

h. Citizenship/Immigration Status: (1) Are you a U.S. Citizen? ☐ Yes ☐ No
(2) Are you lawfully present in ☐ Yes ☐ No ☐ I Don't Know the U.S. and a NYS resident?

To be eligible for PE for the Family Planning Benefit Program, you must be a US Citizen or be lawfully present and a NYS resident. If you are not documented, or are a temporary non-immigrant who is not a NYS resident, you may be able to get Medicaid for the treatment of an emergency medical condition or a pregnancy, if you are determined to be otherwise eligible. To apply for this coverage, contact your local department of social services (LDSS) or the Human Resources Administration (HRA), if you live in NYC.

If the answer to **both 1 and 2** is either "No" or "I Don't Know", **STOP the Screening Process**
If the answer to **either 1 or 2** is "Yes", **CONTINUE the Screening Process**

2. HEALTH INSURANCE

Public Health Insurance:

Do you have or have you recently applied for:

Medicaid (MA)	☐ Yes	☐ No
Child Health Plus (CHPlus)	☐ Yes	☐ No
Temporary Cash Assistance (TA)	☐ Yes	☐ No

If you are enrolled in Medicaid, or Temporary Cash Assistance, you are not eligible for the FPBP. If you have recently applied for these programs, contact the place where you applied and follow through on the completion of your current application. If you already have CHPlus, you may still apply for PE for the FPBP if you need confidential family planning services.

If you have received services in the past and you know your CIN, enter it here ______________________

Do you have Medicare? ☐ Yes ☐ No

Are your Medicare premiums being paid by Medicaid? ☐ Yes ☐ No

Private or Employer Sponsored Health Insurance (Optional):

Are you covered by any other health insurance or plan? ☐ Yes ☐ No

If yes, what is the name of the Health Insurance Plan? ______________________

What is the policyholder's name and their relationship to you? ______________________

3. GOOD CAUSE QUESTION

a. Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of family planning services? ☐ Yes ☐ No

b. Good Cause Authorization

If 3(a) is "Yes", Provider must call 1-800-541-2831 for a Good Cause Authorization

Good Cause Authorization Call Date: ______________________ Approved? ☐ Yes ☐ No

Name of Call Center Representative: ______________________

Duration of Good Cause: From ____________ to ____________

4. HOUSEHOLD SIZE

Count these individuals in your household:

	APPLICANT		1	
	# of parents of applying individual living in HH		______	
	# of applicant's siblings living in HH		______	
	# of applicant's children (under 21) living in HH		______	
	Spouse of applicant living in HH	+	______	
a.	**HH size**	=	______	**Total HH Size**

Note: If a member of the applicant's household is pregnant, they should be counted as them-self plus one.

5. INCOME

a. Applicant's total monthly **gross** income (Before taxes and any deductions) $__________

Include all wages, tips, commissions, self-employment income, Social Security retirement, survivors, and disability benefits, alimony, unemployment benefits, disability payments, etc.
(Do not include grants or loans of students or any Temporary Cash Assistance or SSI payments).

6. PRESUMPTIVE ELIGIBILITY FOR FPBP DETERMINATION

Compare the monthly income amount on line 5(a) to 223% of the FPL for the applicable HH size on line 4a.
If the Monthly Income is:
***Less than or equal to 223% of the FPL for the applicable HH size:** ☐ Yes
Applicant IS Presumptively Eligible for the FPBP. Give PE Determination Letter and FPBP Document Checklist to the individual.
Provider must submit PE Screening Form, PE Determination Letter and FPBP Document Checklist to the NYSDOH Designated Agent within five (5) business days of the determination date. The PE individual must also sign, date and complete an application for the FPBP (DOH-4282) to have eligibility determined for ongoing FPBP services. If a signed, dated and completed application for FPBP was completed, forward it and any documents provided, that should also be included or later forwarded to the NYSDOH Designated Agent.
***More than 223% of the FPL for the applicable HH size:** ☐ Yes
Applicant IS NOT Presumptively Eligible for the FPBP. No further action is required. Give applicant PE Determination Letter.

7. CONTACT INFORMATION AND DETERMINATION DATE

FPBP Provider Agency Name:______________________________

Provider Site Address:______________________________

Screener's Phone Number (with area code): (______ **)** ______________ **ext.**

Screener's Fax Number (with area code): (______ **)** ______________ **ext.**

Screener's Name:______________________________

Screener's Signature:______________________________

Date Screening Form/Determination Completed: ______ / ______ / ________
MM DD YYYY

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Family Planning Benefit Program Application

Please print clearly. Please ask for help if there is anything you do not understand.

SECTION A APPLICANT INFORMATION

Tell us who you are and how to contact you. (PLEASE USE YOUR FULL LEGAL NAME)

First Name, Middle Initial, Last Name				Primary Language	
Home Address Street	Apt. No.	City	State	Zip Code	County of Residence

If you cannot receive mail or a benefit card at your home address due to confidentiality concerns or for other reasons, please give a different mailing address below. If you do not need to give a different mailing address, please check the box marked 'No confidential address needed'.

☐ No confidential address needed.

Mailing Address Street	Apt. No.	City	State	Zip Code	Phone Number

Are you a veteran? ☐ Yes ☐ No

SECTION B HOUSEHOLD INFORMATION

List your name and the names of the people in your family who live with you. You may list your spouse and your children under 21, even though they are not applying.

First Name, Middle Initial, Last Name (Use Another Page if You Need to List More People)	Relationship to Person on Line 1	Date of Birth (MM/DD/YY)	Sex M, F, X	Gender Identity* (Optional)	FOR FPBP APPLICANT ONLY Social Security Number	Race/Ethnic Group (See Codes Below)
1	Self	/ /			– –	
2						
3						
4						

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.
Gender Identity Codes: **M**-Male, **F**-Female, **N**-Non-Binary or Non-Conforming, **X**-X, T-Transgender, **D**-Different Identity: Describe your Identity in space provided.
Race/Ethnic Group Codes: **B**-Black or African American, **W**-White H-Hispanic or Latino, ****A**-Asian or Pacific Islander, **I**-American Indian or Alaskan Native, ****P**-Native Hawaiian or other Pacific Islander, **U**-Unknown, **O**-Other.
**If you have selected A- Asian, or P- Native Hawaiian or Pacific Islander please see below information on Other AAPI.
†Other Asian American/Pacific Islander (optional) - Please identify your AAPI subgroup. Subgroups within this community include, but are not limited to: Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan, Taiwanese, Native Hawaiian, Samoan, Tongan, Guamanian or Chamorro, Marshallese, Fijian, and other.

SECTION C INCOME

List ALL of the type(s) and amount(s) of money you receive. Be sure to include earnings from work (including self-employment), unemployment benefits, interest, Social Security benefits, pensions, disability payments, money from relatives or friends, or any other payments.

Type of Income (Wages, UIB, SSA Benefits)	Amount of Gross Income (Before Taxes/Deductions)	How Often is the Income Received? (Weekly, Every Two Weeks, Monthly, Other)

If you have no income, please explain how you are meeting your needs (for example; living with friends or relatives):

Do you have any unpaid medical bills, related to family planning, from the last 3 months? ☐ Yes ☐ No
If yes, you must provide proof of your income and residency for the month(s) when unpaid services were received.

Have you started or ended a job in the last 6 months? If Yes, please give details below:

SECTION D CITIZENSHIP/IMMIGRATION STATUS

Are you a U.S. citizen, national or Native American? ☐ Yes ☐ No
If No, please give the following information. Your answers to these questions will be kept completely confidential.

First Name, Middle Initial, Last Name	Please mark one box that indicates your current Citizenship or Immigration Status.
	☐ Immigrant/non-citizen (Enter the date you entered the United States ___/____/____) ☐ Non-immigrant (Visa holder) ☐ None of the above

SECTION E HEALTH INSURANCE

You may still be eligible even if you have other health insurance, especially if it does not cover family planning services, or if you have a 'good cause' reason that your health insurance should not be billed.

Do you have coverage through any of the following? ☐ Medicaid ☐ Medicare ☐ Child Health Plus

Do you have other private health insurance? ☐ Yes ☐ No ☐ I Don't Know If Yes:

Name(s) of Person(s) Covered	
Name of Policy Holder/Subscriber	
Insurance Company Name	Group /Policy Number

Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of family planning services? ☐ Yes ☐ No

If Yes, please ask your provider to call for 'Good Cause'

GOOD CAUSE AUTHORIZATION

If above answer is Yes, provider must call 1-800-541-2831 for a Good Cause Authorization.
(This does not need to be done if this application is accompanying a PE Screening and authorization for Good Cause was granted at that time).

Good Cause Authorization Call Date: ____________ Approved? ☐ Yes ☐ No

Name of Call Center Representative: ____________ Duration of Good Cause: From ________ to ________

TERMS, RIGHTS, AND RESPONSIBILITIES

By completing and signing this application, I am applying for the Family Planning Benefit Program (FPBP). I agree to the release of personal and financial information from this application and any other information to determine eligibility. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

I understand that I must provide the information needed to prove my eligibility. If I have been unable to get the information, I will tell the New York State Department of Health (SDOH) or its designee. The SDOH or its designee may be able to help in getting the information.

I understand the FPBP may check the information given by me for this application without my confidentiality being compromised. The state, social services district and provider who assist in completing this application will keep the information confidential according to 42 U.S.C. 1396a(a)(7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.

I understand that my eligibility for this program will not be affected by my race, color, disability, sex, or national origin. I also understand that depending on the requirements of this program my citizenship/immigration status may be a factor in whether or not I am eligible.

I understand that anyone who knowingly lies or hides the truth in order to receive services under this program is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and may also be given civil penalties.

I understand that I must provide documentation of my citizenship and identity to the SDOH or its designee or to the Family Planning Provider on behalf of the SDOH to receive Family Planning Benefits. I also understand that SDOH or its designee can assist me in determining my status and obtaining any necessary documents if I request help. Once I have provided my documents proving my citizenship and identity, I will not have to provide them again. If I am filling out this form as a mail-in renewal, and have not yet provided these documents, I will need to provide them.

Immigration: United States Citizenship and Immigration Services (USCIS) has said that enrollment in Medicaid CANNOT affect a person's ability to get an identification card, become a citizen, sponsor a family member or travel in and out of the country (except if Medicaid pays for long term care in a place like a nursing home or a psychiatric hospital).

The State will not report any information on this application to the USCIS.

ASSIGNMENT OF RIGHTS FOR MEDICAL SUPPORT AND THIRD PARTY PAYMENT

I understand that FPBP does not pay medical expenses that insurance or another person is supposed to pay, unless there is good cause not to use other insurance. All persons applying for FPBP are required to give the SDOH or its designee any rights they may have to medical support or other insurance payment for family planning services, unless they request and receive a good cause exemption. When I sign this application for myself, or for another person for whom I can legally give away rights, I am giving to the SDOH or its designee all of my rights to receive medical support and third party payments for family planning services for the entire time I am on Medicaid.

REIMBURSEMENT OF MEDICAL EXPENSES

After the date of my application, reimbursement of covered family planning services and supplies will only be available if obtained from Medicaid-enrolled providers.

SOCIAL SECURITY NUMBER (SSN)

I understand that I must give my SSN in order to receive FPBP. This is required by section 1137(a) of the Social Security Act and the Medicaid regulations (42 CFR 435.910 and 42 U.S.C. 1320b-7(a)). The FPBP will use the SSN to verify my income, eligibility and the amount of medical assistance payments made on my behalf. The information may be matched with records in other agencies, such as the Social Security Administration and/or the Internal Revenue Service.

CONFIDENTIALITY STATEMENT

All of the information you provide to us will remain confidential. The only people who will see this information are the state or local agencies and the person assisting you in completing the application that need to know this information in order to determine if you are eligible.
The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies that need this information.

RELEASE OF MEDICAL INFORMATION

I consent to the release of any medical information about me and any member of my family for whom I can give consent by: my Primary Care Providers, any other health care provider, or the SDOH or its designee and any health care provider involved in caring for me or my family, as reasonably necessary for my providers to carry about treatment, payment, or health care operations, to SDOH or its designee and other authorized federal state, and local agencies for purposed of administration of the Medicaid program. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law.

I certify that I have read and understand the Terms, Rights and Responsibilities above. I certify under penalty of perjury that everything on this application is the truth as best I know.

Date ____________________ Applicant's Signature ____

DECLINATION OF MEDICAID ELIGIBILITY DETERMINATION

I, ____________________________________, have been informed of the enhanced benefits and additional services and coverage available under Medicaid. I choose not to apply for Medicaid at this time, and have requested an eligibility determination for the Family Planning Benefit Program only. I understand that I may apply for Medicaid or other insurance programs at any time in the future if I wish.

Date __________ Applicant's Signature ____________________ Provider/Medicaid Staff Signature ____________________

AUTHORIZED REPRESENTATIVE DESIGNATION

By signing below, you are allowing another person or agency to apply for Family Planning Benefits for you, discuss your application or case if needed, and receive notices and/or correspondence on your behalf.

Name and address of person or agency to be given general health information:

Name: ____________________ Address: ____________________ Phone Number: __________

Date __________ Applicant's Signature ____________________ Representative's Signature ____________________

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

NYS Medicaid Insurance for NYC OTB Employees and Retirees Application

PLEASE ANSWER **ALL** QUESTIONS. **DO NOT** WRITE IN THE SHADED AREAS. PLEASE **PRINT** CLEARLY, AND SIGN THE APPLICATION ON PAGE 2. **COMPLETE THE WHITE BOXES BELOW IN BLUE OR BLACK INK.** YOU MUST ATTACH PROOF OF IDENTITY AND RESIDENCE.

APPLICANT INFORMATION

FIRST NAME (LEGAL NAME)	MI	LAST NAME

OTHER NAMES BY WHICH I HAVE BEEN KNOWN ARE:

OTHER NAME	OTHER NAME

CURRENT STREET ADDRESS	APT #	CITY

STATE	ZIP CODE	COUNTY	DAYTIME PHONE NUMBER (AREA CODE + PHONE NO.)

MY MAILING ADDRESS (IF DIFFERENT FROM ABOVE) IS:

ADDRESS	APT #	CITY	COUNTY	STATE	ZIP CODE

LIST EVERYONE INCLUDING YOURSELF WHO CURRENTLY LIVES IN THE SAME HOUSE (If no one else, write NONE UNDER YOUR NAME):

LN	FIRST NAME	MI	LAST NAME	DATE OF BIRTH MM	DD	YYYY	SEX M, F, X	GENDER IDENTITY (OPTIONAL)*	RELATION TO ME	SOCIAL SECURITY NO.	RACE/ETHNIC GROUP (SEE CODES BELOW)
01									SELF		
02											
03											
04											
05											

***Gender Identity:** Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.
Gender Identity Codes: **M**-Male, **F**-Female, **N**-Non-Binary or Non-Conforming, **X**-X, T-Transgender, **D**-Different Identity: Describe your Identity in space provided.
Race/Ethnic Group Codes: **B**-Black or African American, **W**-White H-Hispanic or Latino, ****A**-Asian or Pacific Islander, **I**-American Indian or Alaskan Native, ****P**-Native Hawaiian or other Pacific Islander, **U**-Unknown, **O**-Other.
**If you have selected A- Asian, or P- Native Hawaiian or Pacific Islander please see below information on Other AAPI.
†Other Asian American/Pacific Islander (Optional) - Please identify your AAPI subgroup. Subgroups within this community include, but are not limited to: Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan, Taiwanese, Native Hawaiian, Samoan, Tongan, Guamanian or Chamorro, Marshallese, Fijian, and other.

IS THE APPLICANT A NEW YORK STATE RESIDENT WHO IS A RETIREE OR EMPLOYEE OF THE NEW YORK CITY OFF-TRACK BETTING CORPORATION WITH VESTED PENSION TIME OR CREDIT AS OF DECEMBER 7, 2010?
(If the answer is **NO**, then you are not eligible for this program.) ☐ Yes ☐ No

APPLICANT MEDICARE INFORMATION		MEDICARE #			
DO YOU HAVE MEDICARE PART A? ☐ Yes ☐ No	EFFECTIVE DATE:	MM	DD	YYYY	PREMIUM AMOUNT:
DO YOU HAVE MEDICARE PART B? ☐ Yes ☐ No	EFFECTIVE DATE:	MM	DD	YYYY	/mo.

SPOUSE MEDICARE INFORMATION		MEDICARE #			
DO YOU HAVE MEDICARE PART A? ☐ Yes ☐ No	EFFECTIVE DATE:	MM	DD	YYYY	PREMIUM AMOUNT:
DO YOU HAVE MEDICARE PART B? ☐ Yes ☐ No	EFFECTIVE DATE:	MM	DD	YYYY	/mo.

MEDICAID MAY BE ABLE TO HELP PAY FOR MEDICAL SERVICES YOU RECEIVED IN THE THREE MONTHS BEFORE YOU TURNED IN YOUR APPLICATION FOR HEALTH INSURNACE. DO YOU NEED HELP PAYING MEDICAL BILLS FOR THE LAST 3 MONTHS? ☐ Yes ☐ No

YOU MUST PRESENT YOUR COMMON BENEFIT IDENTIFICATION CARD (CBIC) TO YOUR MEDICAL PROVIDER OR PHARMACY TO ACCESS YOUR MEDICAID BENEFIT. DO YOU NEED A CBIC CARD SENT TO YOU OR YOUR DEPENDANT?	☐ Yes ☐ No (If yes, please list those who need a CBIC card to the right.)	01	
		02	
		03	
		04	
		05	

THIS INSURANCE PROGRAM AND THE PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT.

PENALTIES

I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid 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 Medicaid 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 Medicaid benefits; and such benefits must be used by the other person and not for yourself.

CHANGES

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

SOCIAL SECURITY NUMBER

You must report your SSN. The laws requiring this are: 18NYCRR Sections 351.2, 360-1.2, and 360-3.2(j)(3); 42USC 1320b-7. SSNs are used in many ways by federal, state, and local agencies, both in New York and in other jurisdictions. SSNs are used to check identity.

CERTIFICATION OF CITIZENSHIP & IMMIGRATION STATUS

I certify, under the penalty of perjury, by signing my name on this application, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the United States Citizenship and Immigration Services (USCIS) for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid program.

NON-DISCRIMINATION NOTICE

This application will be considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.

CERTIFICATION

In signing this application, I swear and affirm that the information I have given or will give to the Department of Health as a basis for Medicaid is correct. I understand that Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

CONSENT

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

APPLICANT OR REPRESENTATIVE SIGNATURE	X	**DATE:**	MM	DD	YYYY
SPOUSE SIGNATURE	X	**DATE:**	MM	DD	YYYY
REPRESENTATIVE ADDRESS, PHONE NUMBER AND RELATIONSHIP					

IF AFTER READING AND COMPLETING THIS FORM, YOU DECIDE THAT YOU DO NOT WANT TO APPLY FOR THIS PROGRAM, PLESE SIGN ON THE FOLLOWING LINE AS CONSENT TO WITHDRAW YOUR APPLICATION.

SIGNATURE X	**DATE:**	MM	DD	YYYY

SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION: X				DATE:	EMPLOYED BY:	
ELIGIBILITY DETERMINED BY WORKER:			DATE:	ELIGIBILITY APPROVED BY:		DATE:
CENTRAL OFFICE:	APPLICATION DATE:	UNIT ID:	WORKER ID:	CASE TYPE:	CASE No.:	REUSE IND.
CASE NAME:		DISTRICT:		REGISTRY NO.:		VER.
EFFECTIVE DATE:	MA DISP.	DENIAL	WITHDRAWAL	REASON CODE:	PROXY: ☐ Yes ☐ No	

PLEASE MAIL COMPLETED APPLICATION TO:		NYS Department of Health - OHIP Stakeholder Relations and Exchange Support, Attn: OTB Medicaid One Commerce Plaza, 8th FL Albany, NY 12237-0004	
IF YOU HAVE ANY QUESTIONS, PLEASE CALL:	(518) 457-0761	**FAX NUMBER:**	(518) 474-4959

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicare Savings Program Application

Please print clearly and do not write in the dark shaded area.

APPLICANT

First Name, Middle Initial, Last Name			Home Phone Number ( )	
Home Address Street Apt. No.	City	State	Zip Code	County

Is this a shelter? ☐ Yes ☐ No

Mailing Address Street/P.O. Box (If Different from Above) Apt. No.	City	State	Zip Code	County

NAMES

List your name first. Include aliases and maiden name. If necessary, attach an extra sheet to list all children.

First Name, Middle Initial, Last Name	Date of Birth (MM/DD/YY)	Sex M, F, X	Gender Identity** (Optional)	Social Security Number	Race/Ethnicity Group (See codes below)
Self	/ /			– –	
Spouse	/ /			– –	
Child*	/ /			– –	
Child*	/ /			– –	

*If under 18 years of age

**Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.

Gender Identity Codes: **M**-Male, **F**-Female, **N**-Non-Binary or Non-Conforming, **X**-X, **T**-Transgender, **D**-Different Identity: Describe your Identity in space provided.

Race/Ethnic Group Codes: **B**-Black or African American, **W**-White, **H**-Hispanic or Latino, †**A**-Asian or Pacific Islander, **I**-American Indian or Alaskan Native, †**P**-Native Hawaiian or other Pacific Islander, **U**-Unknown, **O**-Other.

†If you have selected **A**-Asian, or **P**-Native Hawaiian or Pacific Islander please see below information on Other AAPI.

‡Other Asian American/Pacific Islander (optional) - Please identify your AAPI subgroup. Subgroups within this community include, but are not limited to: Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan, Taiwanese, Native Hawaiian, Samoan, Tongan, Guamanian or Chamorro, Marshallese, Fijian, and other.

CITIZENSHIP INFORMATION

Are you a U.S. citizen? ☐ Yes ☐ No

If No, do you have satisfactory immigration status? ☐ Yes ☐ No Include alien number, date of status, and date entered country, if applicable.

Alien Number	Date of Status (DOS)	Date Entered Country (DEC)

Is your spouse a U.S. citizen? ☐ Yes ☐ No

If No, does your spouse have satisfactory immigration status? ☐ Yes ☐ No Include alien number, date of status, and date entered country, if applicable.

Alien Number	Date of Status (DOS)	Date Entered Country (DEC)

MEDICARE INFORMATION

Applicant's Medicare Number (From Red and Blue Medicare Card)			
Do you have Medicare Part A? ☐ Yes ☐ No	Effective Date	Do you have Medicare Part B? ☐ Yes ☐ No	Effective Date
Spouse's Medicare Number (From Red and Blue Medicare Card)			
Does your spouse have Medicare Part A? ☐ Yes ☐ No	Effective Date	Does your spouse have Medicare Part B? ☐ Yes ☐ No	Effective Date

Would you like us to consider providing retroactive reimbursement of your Medicare premium? ☐ Yes ☐ No

Do you or your spouse pay any health insurance premiums other than Medicare? ☐ Yes ☐ No

Who?	Monthly Amount $

Do you or your spouse pay child/spousal support? ☐ Yes ☐ No

Who?	Monthly Amount $

Do you or your spouse receive payments from or are named beneficiary of a trust? ☐ Yes ☐ No

Who?	Value $

INCOME

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc. If necessary, attach an extra sheet to list all sources of income.

Name of Applicant, Spouse, or Child Under 18	Who Provides the Money? (Name/Source of Income)	What Amount?	How Often? (Weekly, Every Two Weeks, Monthly, Other)

Do you want to receive notices in: ☐ English Only ☐ Spanish and English?

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 Medicaid. If additional information is requested, I will provide it.

SIGNATURES

Applicant/Representative Signature			Date
Spouse Signature			Date
Representative Address			Relationship
City	State	ZIP Code	Phone Number ( )

INSTRUCTIONS

PLEASE TYPE OR PRINT LEGIBLY

COMPLETE THE APPLICATION

Be sure to answer all the questions. If you are married and living with your spouse, you must complete both the "Self" and "Spouse" questions on the application (even if the spouse is not applying for the MSP).

SIGN AND DATE THE APPLICATION

If both spouses are applying, both must sign the MSP application.

INCLUDE THE FOLLOWING VERIFICATION DOCUMENTS

Please review this list and submit the documents that you will need to provide in order for the Medicaid Program to determine if you are eligible for MSP. If you are requesting retroactive reimbursement of your Medicare premiums, you must send proof of income for the previous three-months. If there is an applying spouse, the spouse must also provide documentation.

- A photocopy of the front and back of your **Medicare card**.
- **Proof of income:** Paycheck stubs, letter from employer, income tax return, award letter for any unearned income benefit such as social security, unemployment, or veteran's benefit, or letter from renter, boarder or tenant.
- **Health insurance premiums that you pay other than Medicare:** Letter from employer, premium statement, or pay stub.
- **Proof of date of birth:** State driver's license, U.S. birth certificate, permanent resident card ("green card"), or NYS Benefit Identification Card.
- **Proof of residence:** Lease/letter/rent receipt with your home address from your landlord, driver's license (if issued in the past 6 months), utility bill (gas, electric, phone, cable, fuel or water), government ID card with address, property tax records or mortgage statement, or postmarked envelope or postcard (cannot use if sent to a P.O. Box).
- If you are not a U.S. citizen, you must provide documents indicating your current immigration status.

Mail the application and required documentation to your local Department of Social Services (LDSS) or Human Resource Administration (HRA). To find the address in your county: http://www.health.ny.gov/health_care/medicaid/ldss.htm.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying for the Medicare Savings Program. **PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT.**

PENALTIES

I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid 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.

CHANGES

I agree to immediately report any changes to the information on this application.

SOCIAL SECURITY NUMBER (SSN)

If you are applying for the Medicare Savings Program, you must report your SSN. The laws requiring this are: 18NYCRR Sections 351.2, 360-1.2, and 360-3.2(j)(3); 42USC 1320b-7. SSNs are used in many ways, both within the local social services districts and also between local social services districts and federal, state, and local agencies, both in New York and in other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if absent parents can get health insurance for applicants, to see if applicants can get child support and to see if applicants can get money or other help.

CERTIFICATION OF CITIZENSHIP & IMMIGRATION STATUS

I certify, under the penalty of perjury, by signing my name on this application, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the United States Citizenship and Immigration Services (USCIS) for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid program.

NON-DISCRIMINATION NOTICE

This application will be considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.

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 Medicaid 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 Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program, please sign your name below:

I consent to withdraw my application:

Applicant Signature	Date

Signature of Person Who Obtained Eligibility Information			Date	Employed By			
Date Eligibility Determined By Worker				Date Eligibility Approved By			
Central/Office	Application Date	Unit ID	Worker ID	Case Type	Case No.		Reuse Ind.
Case Name		District		Registry No.		Ver.	
Effective Date	MA Disp.	Denial	Withdrawal	Reason Code		Proxy ☐ Yes ☐ No	

NEW YORK STATE DEPARTMENT OF HEALTH
Disability Review Unit

Medical Report for Determination of Disability

Section I – Identification

Agency
State Disability Review Unit OCP-826
State of New York
Department of Health
Albany, NY 12237
Telephone Number: 1(866) 330-0591

Patient
Name (Last, First, Middle)

Address (Street, City, State & Zip Code):

Client ID Number

Disability ID Number

Date of Birth
/ /

*Gender Identity (optional)
☐ **M**-Male, ☐ **F**-Female,
☐ **N**-Non-Binary or Non-Conforming,
☐ **X**-X, ☐ **T**-Transgender,
☐ **D**-Different Identity: Describe your Identity in space provided below.

Case Number

SSN (last four digits)

Sex
☐ Male ☐ Female ☐ X

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth.

Section I – Medical Report – Note to Provider

This individual has made an application (reapplication) for Disability Medicaid. Your cooperation in completing this form to show the individual's current condition, focusing on both remaining capabilities and limitations, is requested. Your promptness will ensure an early decision on the individual's application.

Please return the completed form to the agency in Section I above, along with a copy of all medical records for the past 12 months.

Diagnosis(es)

Date of last exam ________
Height ________ ft. ________ in.
Weight ________ lbs.

Exertional Functions. Please indicate what the individual is CAPABLE of doing:

Lifting
☐ < 10 lbs.
☐ Max. 10 lbs.
☐ Max. 20 lbs./freq. 10 lbs.
☐ Max. 50 lbs./freq. 25 lbs.
☐ > 50 lbs.

Carrying
☐ < 10 lbs.
☐ Max. 10 lbs.
☐ Max. 20 lbs./freq. 10 lbs.
☐ Max. 50 lbs./freq. 25 lbs.
☐ > 50 lbs.

Standing
☐ < 2 hrs./day
☐ 2 hrs./day
☐ 6 hrs./day

Walking
☐ < 2 hrs./day
☐ 2 hrs./day
☐ 6 hrs./day

Sitting
☐ < 6 hrs./day
☐ 6 hrs./day

Pushing
☐ Using R arm
☐ Using L arm
☐ Using R leg
☐ Using L leg

Pulling
☐ Using R arm
☐ Using L arm

Non-Exertional Functions. Please check if LIMITATIONS exist in any of the areas below:

Sensory
☐ No Limitations
☐ Seeing
☐ Hearing
☐ Speaking

Postural
☐ No Limitations
☐ Stooping/Bending
☐ Crouching/Squatting
☐ Climbing

Manipulative
☐ No Limitations
☐ R Upper Extremity
☐ L Upper Extremity

Environmental
☐ No Limitations
☐ Tolerating dust, fumes, extremes of temperature
☐ Tolerating exposure to heights or machinery
☐ Operating a motor vehicle

Mental
☐ No Limitations
☐ Understanding, carrying out, remembering instructions
☐ Making simple work-related decisions
☐ Responding appropriately to supervision, co-workers, work situations
☐ Dealing with changes in a routine work setting

Provider Signature

Print Name

Date Signed

Specialty

Office Address

Office Phone Number

PLEASE RETURN THIS FORM **ALONG WITH A COPY OF ALL MEDICAL RECORDS FOR THE PAST 12 MONTHS.**

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Renewal for Medicaid (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

RECERTIFICATION REFLECTS
☐ No change
☐ Change
☐ Outstanding documentation needed

CENTER/OFFICE	UNIT ID	WORKER ID	CASE TYPE	CASE NUMBER	DISTRICT
			2 0		

CASE NAME **NAME OF INDIVIDUAL INTERVIEWED** **CATEGORIES**

MA ELIGIBILITY DATES

From			To		
Month	Day	Year	Month	Day	Year

RECIPIENT'S INFORMATION

FIRST NAME	MI	LAST NAME	DATE OF BIRTH Month	Day	Year

SEX ☐MALE ☐FEMALE ☐ X

GENDER IDENTITY (OPTIONAL)* (SEE CODES BELOW)

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth. Gender Identity Codes: **M**-Male, **F**-Female, **N**-Non-Binary or Non-Conforming, **X**-X, **T**-Transgender, **D**-Different Identity: Describe your Identity in space provided.

SOCIAL SECURITY NUMBER	LIST OTHER NAMES RECIPIENT HAS BEEN KNOWN BY	ONC

NAME AND ADDRESS OF RECIPIENT'S FACILITY

RECIPIENT'S SPOUSE'S INFORMATION

SPOUSE'S FIRST NAME	MI	SPOUSE'S LAST NAME	DATE OF BIRTH Month	Day	Year

SPOUSE IS DECEASED ☐YES ☐NO	IS SPOUSE APPLYING/RECERTIFYING/RECEIVING? ☐YES ☐ NO	SPOUSE'S SOCIAL SECURITY NUMBER
SPOUSE'S ADDRESS		SPOUSE'S PHONE NUMBER ( )

LIST AND OTHER 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 Month	Day	Year

WHAT IS THE 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 ( )

RESOURCES

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				Year	Make	Model

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

YES	NO	ASSET	$ VALUE	WHO DID IT GO TO?

Do Not Write in the Shaded Area.

Do Not Write in the Shaded Area.

INCOME

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

Do you have Medicare (Red, White, and Blue card)? ☐ Yes ☐No If Yes, ☐Part A ☐Part B

Does your 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? ☐ 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? ☐Yes ☐No If Yes, fill in the Requested Information below.

MONTHLY RENTAL 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)

Race/Ethnic Group Codes: ☐ **B**-Black or African American ☐ **W**-White ☐ **H**-Hispanic or Latino ☐ ***A**-Asian or Pacific Islander
☐ **I**-American Indian or Alaskan Native ☐ ***P**-Native Hawaiian or other Pacific Islander ☐ **U**-Unknown ☐ **O**-Other. ____________

*If you have selected A-Asian, or P-Native Hawaiian or Pacific Islander please see below information on Other AAPI.

†Other Asian American/Pacific Islander (optional) - Please identify your AAPI subgroup. Subgroups within this community include, but are not limited to: Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan, Taiwanese, Native Hawaiian, Samoan, Tongan, Guamanian or Chamorro, Marshallese, Fijian, and other.

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 Medicaid (MA) shall disclose the Social Security Number of any person for whom Medicaid 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 Medicaid 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 Medicaid 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 Medicaid. 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 Medicaid.

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 Medicaid.

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 or both if you do not tell the truth when you apply for Medicaid 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 Medicaid 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 Medicaid 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 their spouse within or after the sixty months immediately preceding the first day of the month in which the individual becomes institutionalized, or the date of application for Medicaid 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 Medicaid 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 upon receipt of Medicaid, 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 Medicaid 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	Supervisor's Signature	Date Signed

Medicaid Cancer Treatment
Program Application

Breast, Cervical, Colorectal and Prostate Cancer

New York State Department of Health

Instructions

CONFIDENTIALITY STATEMENT

All of the information you provide on this application will remain confidential. The only people who will see this information are the Cancer Services Program Partnerships (CSPP), the State Department of Health, or local Department of Social Services who need to know this information in order to administer the Medicaid Program. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State Department of Health which needs this information.

PLEASE READ the entire application, instructions and document checklist before you fill out the application. (Refer to the documentation checklist for acceptable required documents.) If you need more space to list information, use the Additional Information section.

Social Security Number. A social security number must be provided for all persons applying. If you do not have a social security number you must apply for one.

Race/Ethnic Affiliation. This information is optional. It is asked to make sure all people have access to the program. If you fill out this information, check the box on the application that best describes your race or ethnic background.

Section A:

APPLICATION SHOULD BE FILLED OUT BY THE CSPP STAFF AND APPLICANT

Section B: PERSONAL DATA

In this section, we ask for information about how to contact the applicant. The home address is where the person applying for health insurance lives. The mailing address, if different, is where the Benefit Identification Card and all notices will be sent. Please include apartment number.

Section C: HOUSEHOLD INFORMATION

These questions help us determine which program is best for the applicant. You may be eligible for Medicaid under one of the other Mandatory Medicaid Categorical groups.

1) Indicate if you are pregnant. Indicate the date the baby is due.
2) Fill out the information requested for each dependant child under 21 years of age living in the household.
3) To determine your household composition, it is important for us to know if the child's parent or your spouse is living in the home.
4) Indicate your monthly housing payment, type of heat and if the heat is included in the rent.
5) Answer YES if you consider yourself disabled or you receive cash benefits based on a disability.
6) It is important to tell us whether you have health insurance or are covered by someone else's insurance. If you are covered by health insurance, you must provide documentation that breast, cervical, colorectal and/or prostate cancer services are not covered by your insurance.
7) Applicants must show proof of satisfactory U.S. citizenship or immigration status.

To be eligible for the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer (MCTP) persons must be a U.S. Citizen, National, Native American or fall into one of many immigration categories. *Temporary Workers, Visitors or Foreign Students are not eligible for the MCTP.*

A person with satisfactory immigration status will fall under one of the following:

- Legal Permanent Resident (green card holder)
- Asylee
- Refugee
- Amerasian
- Cuban/Haitian Entrant
- Withholding of Deportation
- Conditional Entrant
- Parolee at least one year
- Native American born in Canada who is at least 50% Native American
- Battered/Abused immigrants
- Order of Supervision
- Stay of Deportation
- Voluntary Departure
- Deferred Action Status
- Suspension of Deportation
- Parolee for less than one year
- Covered by an approved immediate relative petition
- Property filed or granted application for adjustment of status
- Has continuously lived in the United States since before January 1, 1972
- Living in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure the federal immigration agency does not contemplate enforcing.

The State will not report any information on this application to the federal immigration agency.

Instructions continued on the inside back page

Instructions (continued)

8) At the time of the interview, you will be asked about the total amount of money received each month from wages, salaries, tips, Social Security benefits, disability benefits, unemployment benefits, veteran's benefits, alimony, or rental income. If you have no income, please indicate none. Please include any money that anyone gives you each month to help meet living expenses. This information will be used for the purpose of determining if you might be eligible for Medicaid under one of the Mandatory Medicaid Categorical groups.

9) At the time of the interview, you will be asked about the total value of your resources. Examples of resources include such things as money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, or property that someone owns. Do not count the value of your home. The value of your resources does not make you ineligible for the MCTP, but this information will be used for the purpose of determining if you might be eligible for Medicaid under one of the Mandatory Medicaid Categorical groups.

10) Please indicate if you are receiving Cash Assistance, Supplemental Security Income (SSI), Medicaid, Medicare or other financial assistance.

11) Is anyone in the household on full time duty in the U.S. Army, Navy, Air Force, Marine Corps, Coast Guard or a veteran of the Armed Forces? Answer yes or no and enter the person's name on the line provided.

Section D: RETROACTIVE MEDICAID

If you have paid or unpaid medical bills from the past 3 months, MCTP may be able to pay for these costs. If you want us to determine your eligibility for retroactive Medicaid coverage, check the appropriate box. Include copies of medical bills with this application.

Section E: APPLICANT RELEASE AGREEMENT

By signing this agreement you give permission for the information on this application to be shared with the State Medicaid Program, NYS Medicaid Cancer Treatment Program, the local Department of Social Services, the NYS Cancer Services Program and the Cancer Services Program Partnerships. The information is being shared for the purpose of administering the Medicaid Program.

Section F: NYS BREAST, CERVICAL, COLORECTAL AND PROSTATE CANCER SCREENING AND DIAGNOSIS CERTIFICATION

This section is to be completed by the New York State Department of Health's Cancer Services Program.

Section G: MEDICAL REFERRAL

Have your health care provider complete the medical information portion of this form and return it to the Cancer Services Program Partnerships by the date indicated below.

Section H: APPLICANT RELEASE AGREEMENT

You must sign the release agreement on the Medical Referral Form. By signing this medical information release, you give permission for your health care provider to share your personal medical information with the State Medicaid program, New York State Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer, the local Department of Social Services, the Cancer Services Program Partnerships, and the Cancer Services Program.

Your application cannot be completed until all required items are received.

Please return these items by ___________________.

If you need help getting any of these items, contact your Cancer Services Program Partnership.

Terms, Rights and Responsibilities

By completing and signing this application, I am applying for the Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer. I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid, I will tell the Cancer Services Program Partnerships. The Cancer Services Program Partnerships may be able to help in getting the information.
- I understand that workers from the programs for which I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307 and any federal and state laws and regulations.
- I understand that Medicaid will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid I am giving to the Medicaid agency all of my rights to receive medical support from a spouse or parents of persons under 21 years old and my right to third party payments for the entire time I am on Medicaid.
- I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties.

CSPP Name and Address

Department of Health

DOCUMENTATION CHECKLIST for Health Insurance

All documentation must be included for the application to be considered complete.

Applicant Name ______________________________ **Application Date**__________________

PROOF OF IDENTITY/CITIZENSHIP/DATE OF BIRTH AND RESIDENCY

You must show documentation of identity, citizenship, date of birth and residency to see if you are eligible for health insurance. For identity/citizenship documentation the Cancer Services Program Partnerships (CSPP) must see the original document or a document certified by the issuing agency. CSPP will make copies of the document and annotate on the copy that they saw the original. You may discuss this with the person helping you with your application.

IDENTITY/CITIZENSHIP/DATE OF BIRTH**

- ☐ Driver's license/Official photo identification
- ☐ U.S. Passport*
- ☐ Birth certificate
- ☐ Baptismal/other religious certificate
- ☐ Official school records
- ☐ Adoption records
- ☐ Official hospital/doctor birth records
- ☐ Certificate of U.S. Citizenship*
- ☐ Certificate of Naturalization*
- ☐ Marriage records

**Satisfies both identity and citizenship documentation.*
***See DOH 4418 for additional documents for identity/citizenship.*

RESIDENCY/HOME ADDRESS*

- ☐ ID card with address
- ☐ Postmarked envelope, postcard, or magazine label with name and date (no P.O. Box)
- ☐ Drivers license issued within past 6 months
- ☐ Letter/lease/rent receipt with home address from landlord
- ☐ Property tax records or mortgage statement
- ☐ Utility bill (gas, electric, cable), bank statement or correspondence from a government agency which contains a street address (not a P.O. Box)

**This must match the home address in Section B and the proof must be dated within 6 months of the application.*

INCOME

- ☐ Current wage stubs
- ☐ Income tax records/return (schedule C)
- ☐ Current award letterr
- ☐ Correspondence from employer
- ☐ Current benefit check
- ☐ Other __________________

ADDITIONAL INFORMATION

If necessary, this section may be used to record additional information.

DOCUMENTATION CHECKLIST for Health Insurance (continued)

IMMIGRATION DOCUMENTS

If not a U.S. Citizen, please give the following information. Your answers to these questions will be kept completely confidential.

Cancer Services Program Partnerships (CSPP) must see the original document or a document certified by the issuing agency. CSPP will make copies of the document and annotate on the copy that they saw the original.

First Name	M.I.	Last Name	**Does this person belong to any of the categories listed below?** ***Check the appropriate box.***	**If box A is checked, enter Date of Status (DOS)** (MM/DD/YYYY)	**If either A or B, enter date when the person entered the U.S. (DEC)** (MM/DD/YYYY)
			☐ A ☐ B ☐ C ☐ None		
			☐ A ☐ B ☐ C ☐ None		
			☐ A ☐ B ☐ C ☐ None		

Check A if the person is under one of the following categories:

- Lawful Permanent Resident (green card holder)
- Asylee
- Refugee
- Amerasian
- Cuban/Haitian Entrant
- Parolee for at least one year
- Withholding of Deportation
- Conditional Entrant
- Native American born in Canada who is at least 50% Native American
- Some battered/abused immigrants

Check B if the person is under one of the following categories:

- Order of Supervision
- Stay of Deportation
- Voluntary Departure
- Deferred Action Status
- Suspension of Deportation
- Parolee for less than one year
- Covered by an approved immediate relative petition
- Properly filed or granted application for adjustment status
- Has lived continuously in the United States since before January 1, 1972
- Living in the United States with the knowledge and permission or acquiescence of the federal immigration agency and whose departure the federal immigration agency does not contemplate enforcing

Check C if the person is a non-immigrant*
Short term visa holders such as:

- Foreign students
- Visitors
- Temporary workers

*Temporary Workers, Visitors or Foreign Students are not eligible for the MCTP (Column C).
The State will not report any information on this application to the federal immigration agency.

MCTP: Breast, Cervical, Colorectal and Prostate Presumptive Medicaid Eligibility Application

SECTION A CSPP INFORMATION - TO BE COMPLETED BY SITE STAFF

CSPP Name ______________________________ CSPP # ☐☐

Address ______________ ______________ ________ ____
STREET CITY STATE ZIP

CSPP Contact Person ______________________________ Phone ( ) __________

Section B PERSONAL DATA - TO BE COMPLETED BY SITE STAFF AND APPLICANT

Name ______________________________ SSN # __________
FIRST MI LAST MAIDEN

Date of Birth ___/___/___/ Marital Status ________ Sex: ☐ M ☐ F ☐ X

Gender Identity (Optional)*: ☐ M-Male, ☐ F-Female, ☐ N-Non-Binary or Non-Conforming, ☐ X-X, T-Transgender,
☐ D-Different Identity, Describe your Identity in space provided: ____________

*Gender Identity: Gender identity is how you perceive yourself and what you call yourself. Your gender identity can be the same as or different from your sex assigned at birth

CSPP Client # ______________

Address ______________ ______________ ________ ____
STREET CITY STATE ZIP

Mailing Address (if different from above) ______________ ______________ ________ ____
STREET / P.O. BOX CITY STATE ZIP

Client Phone # ( ) __________ Primary Language __________ County of Residence ______________

Race/Ethnic Affiliation (Optional): ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White
☐ American Indian or Alaskan Native ☐ Native Hawaiian/Pacific Islander
☐ Other:______________
☐ Other Asian American/Pacific Islander (Optional)**:______________

**Please identify your AAPI subgroup. Subgroups within this community include, but are not limited to: Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan, Taiwanese, Native Hawaiian, Samoan, Tongan, Guamanian or Chamorro, Marshallese, Fijian, and other.

SECTION C HOUSEHOLD INFORMATION (The following questions are being asked to determine if you might be eligible under one of the Mandatory Medicaid Categorical Groups.)

1. Are you pregnant? ☐ Yes ☐ No If **Yes**, Due Date
2. Do you have dependent children under the age of 21 who live with you? ☐ Yes ☐ No If **Yes**, list their names and dates of birth.
   Name ____________ DOB ______ Name ____________ DOB ______
   Name ____________ DOB ______ Name ____________ DOB ______
   Do you pay childcare expenses? ☐ Yes ☐ No
   If **Yes**, $_______ ☐ Weekly ☐ Monthly
3. Does your spouse or the parent of your children live in your home? ☐ Yes ☐ No
4. What is your monthly housing payment? $__________
   Type of heat (gas, oil, etc.) ______ Is heat included in your housing payment? ☐ Yes ☐ No
5. Have you been determined to be disabled by the Social Security Administration or your County/State Medical Review Team?
   ☐ Yes ☐ No
6. Do you have health insurance? ☐ Yes ☐ No If **Yes**, attach a copy of the insurance card.
   Does this insurance provide coverage for treatment of breast, cervical, colorectal or prostate cancer? ☐ Yes ☐ No
   What is the monthly cost of this insurance coverage? $__________
7. Are you a United States citizen, national, Native American or an alien with satisfactory immigration status? ☐ Yes ☐ No
   If **Yes**, attach a copy of proof of citizenship/national, or alien status.

8. How much is your household income? Check the type(s) of money and the amount received:
Earnings From Work: ☐ Weekly ☐ Bi-weekly ☐ Monthly

Wages/Salaries $_________ Commissions $_________ Tips $_________

Overtime $_________ Self-employment $_________ Other $_________

Unearned Income: (Indicate the **monthly** amount)

Social Security Benefits $_________ Disability Payments $_________

Unemployment Benefits $_________ Veteran's Benefits $_________

Worker's Compensation $_________ Child/Support Payments $_________

Alimony $_________ Rental Income $_________

Interest and Dividends $_________ Other $_________

Contributions (money received each month from friends, family or anyone that help meet living expenses) $_________

Total Gross Monthly Income (earned and unearned) $ _________

9. Check all resources that you may have. Resources include:
☐ Cash on hand
☐ Saving/Checking Account(s)
☐ Life Insurance
☐ Real Property (other than your home)
☐ Stocks/Bonds/Certificates/Mutual Funds
☐ IRA/Keogh/401-K or Deferred Compensation Accounts
☐ Burial Trust/Burial Fund
☐ Resources other than those listed above:
Total Value of Resources $ _____________

10. Are you currently receiving any other assistance? ☐ Yes ☐ No
If **Yes**, check all that apply. ☐ Financial assistance ☐ Medicaid ☐ Medicare (A, B or D) ☐ SSI ☐ Other _____________
11. Is anyone in the household a veteran? ☐ Yes ☐ No
If **Yes**, Name ______________________________________

SECTION D APPLICATION FOR RETROACTIVE MEDICAID

Otherwise eligible individuals who have paid or unpaid medical bills may qualify for up to three 30-day periods of coverage before the application date. This is called "Retroactive Medicaid".
Do you wish to apply now for Retroactive Medicaid? ☐ Yes ☐ No
If **Yes**, for which period? Check one:
☐ Within 30 days
☐ Between 30 and 60 days
☐ Between 60 and 90 days (of application date)

SECTION E APPLICANT RELEASE AGREEMENT

I agree that the information on this application may be shared only with the State Medicaid Program, Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer, the local Department of Social Services, the Cancer Services Program Partnerships and the NYS Cancer Services Program providing the application assistance. I understand that this information is being shared for the purpose of administering the Medicaid Program.

I have read and understand the Terms, Rights and Responsibilities included in this application booklet. I certify, under penalty of perjury, that the information I have provided on this application is true and complete to the best of my knowledge.

____
PRINT YOUR FULL NAME

____
APPLICANT SIGNATURE DATE WITNESS SIGNATURE DATE

SECTION F MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL AND PROSTATE SCREENING CERTIFICATION

The Cancer Services Program certifies that the patient named above meets all the CSP eligibility criteria for screening, has received such screening and/or diagnosis and is in need of treatment for breast, cervical, colorectal and/or prostate cancer.

__________________________ __________________
NYS HEALTH PROGRAM COORDINATOR DATE

SECTION G MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL AND PROSTATE CANCER HEALTH INSURANCE MEDICAL REFERRAL

CSPP # ☐☐ CSPP Client # ___________________

Facility/Clinic _________________________________ Phone ( ) __________________

Address ____________________________________ Contact Person _________________

Patient Name ________________________________ Date of Birth __________________

Patient Address ________________________________ SSN ______________________

Patient Phone Number ( ) __________________________

Diagnosis

- ☐ Cervical, Pre-Cancerous Lesion (If subsequent treatment is required)
- ☐ Cervical, In Situ
- ☐ Cervical, Invasive
- ☐ Atypical Ductal Hyperplasia (ADH) (If subsequent treatment is required)
- ☐ Breast Lobular Carcinoma, In Situ (If subsequent treatment is required)
- ☐ Breast, In Situ
- ☐ Breast, Invasive
- ☐ Colorectal, Pre-Cancerous (If subsequent treatment is required)
- ☐ Colorectal, In Situ
- ☐ Colorectal, Invasive
- ☐ Prostate, Atypia
- ☐ Prostate, High Grade Prostatic Intraepithelial Neoplasia (HGPIN)
- ☐ Prostate, Invasive

Date of Diagnosis from original biopsy _____/_____/_____/
MONTH DAY YEAR

Diagnosis/Staging (if available) ____

Treatment Plan ____

____

____

Estimated Length of Treatment (in months) ____

____
PHYSICIAN, NURSE PRACTITIONER, OR LICENSED PHYSICIAN ASSISTANT (SIGNATURE) DATE

____
PHYSICIAN, NURSE PRACTITIONER, OR LICENSED PHYSICIAN ASSISTANT (PRINT NAME)

Please sign and return form to: ____ **By** _____/_____/_____/
FIRST LAST MONTH DAY YEAR

SECTION H APPLICATION RELEASE AGREEMENT

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I agree that the information on this medical referral may be shared only with the State Medicaid Program, Medicaid Cancer Treatment Program: Breast, Cervical, Colorectal and Prostate Cancer, the local Department of Social Services and the Cancer Services Program Partnerships and the Cancer Services Program providing the application assistance. I understand that this information is being shared for the purpose of determining my eligibility for Medicaid. I also agree that the information released may include HIV, mental health, or alcohol and substance abuse information about me to the extent permitted by law.

____
PRINT YOUR FULL NAME

__________________________________ __________________________________
APPLICANT SIGNATURE DATE WITNESS SIGNATURE DATE