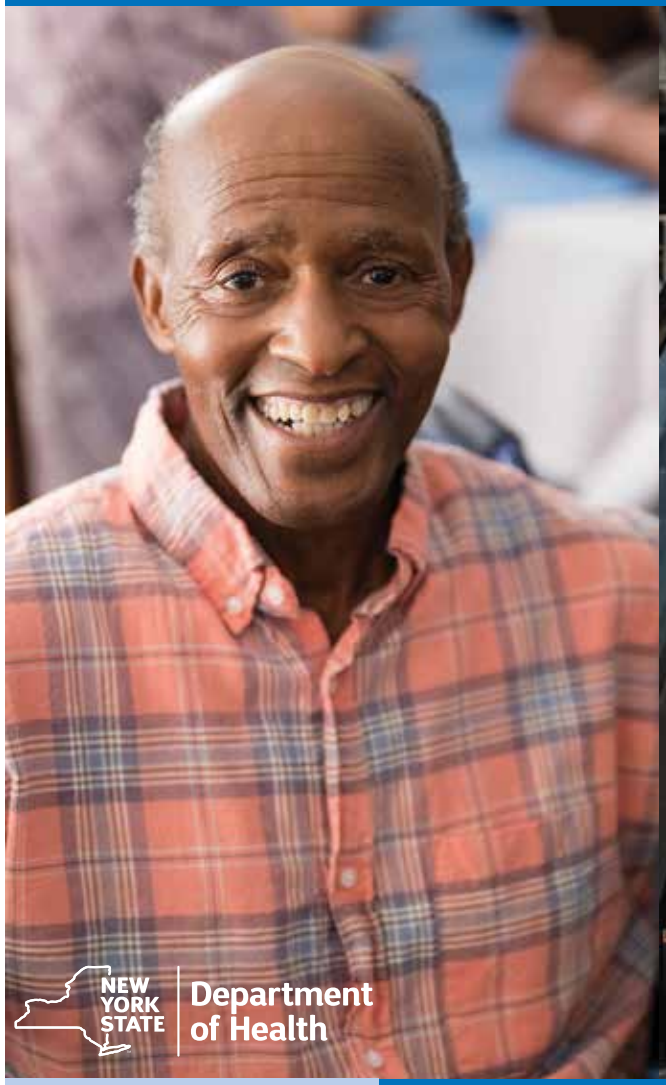

NEW YORK STATE | Department of Health

access NY health care

# Health Insurance

## for Older Adults, People With Disabilities and Certain Other Populations

## APPLICATION

# 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 Assistors and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your family members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.

**PURPOSE OF THIS APPLICATION** Complete this application if you want health insurance to cover medical expenses. This application can be used to apply for Medicaid, the Family Planning Benefit Program, or for assistance paying your health insurance premiums. You can apply for yourself and/or immediate family members living with you.

IF YOU NEED HELP COMPLETING THIS APPLICATION DUE TO A DISABILITY, CALL YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES. THEY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATIONS TO ADDRESS YOUR NEEDS.

**PLEASE READ** **the entire application booklet before you begin to fill out the application. This application, along with Supplement A, must be filled out completely if you are 65 years old or older, certified blind, certified disabled or institutionalized, and/or if you are applying for coverage of nursing home care. Supplement A includes questions about your resources, such as money in the bank or property you own. This application is also used when applying through a provider, for individuals who are pregnant or under 19. If the application is for a pregnant person or child under 19, only Sections A thorough G, I, and J must be completed.**

**Any other Medicaid applicants must apply through NY State of Health. You can contact NY State of Health by visiting their website at https://nystateofhealth.ny.gov/, or by phone at 1-855-355-5777.**

**Whenever you see the words SEND PROOF on the application refer to the "Documents Needed When You Apply for Health Insurance" section for a listing of acceptable supporting documents, pages 4-6.**

**HOW TO GET HELP** When applying for public health insurance, you **DO NOT** need to visit your local department of social services or an Assistor for an interview, but you **MAY** come in or contact an Assistor for help filling out this application. **You can get a list of Assistors where you got this application, or by calling 1-800-698-4543. You may also call the Medicaid help line at 1–800–541–2831. ALL HELP IS FREE.**
**(1-877-898-5849 TTY line for the hearing impaired)**
**After you have completed this application please mail/return to the local department of social services in the county in which you reside.**
**https://www.health.ny.gov/health_care/medicaid/ldss.htm**

## SECTION A Applicant's Information

We need to be able to contact the people applying for health insurance. The home address is where the people applying for health insurance live. The mailing address, if different, is where you want us to send health insurance cards and notices about your case. You can also tell us if you want someone else to get information about your case and/or to be able to discuss your case.

## SECTION B Family Information

Please include information for everyone who lives with you even if they are not applying for health insurance. It is important that you list everyone who lives with you so that we can make a correct eligibility decision. Include legal name before marriage, if this applies to the person. Also include city, state and country of birth. If a person was born outside of the United States, just write the country of birth.

- **Is this person pregnant?** If so, when is the baby due to be born? This information helps us determine the size of your family. A pregnant person counts as two people.
- **Relationship to the person on Line 1.** Explain how each person is related to the person listed on Line 1 (for example, spouse, child, step-child, sibling, grandchild, etc.)
- **Public Health Coverage.** If you or anyone who lives with you is already enrolled or was previously enrolled in Medicaid, the Family Planning Benefit Program, or any other form of public assistance such as the Supplemental Nutrition Assistance Program (SNAP), we need to know which program. Also, tell us the identification number on the New York State Benefit Identification Card.
- **Social Security Number.** A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank.
- **Citizenship and Immigration Status.** This information is needed only for those people applying for health insurance. To be eligible for health insurance, persons age 19 and over must be U.S. citizens or be lawfully present. If we are unable to verify your U.S. Citizenship and identity electronically through federal databases, we will need to see documentation of U.S. citizenship and identity. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring these documents. Please note that if you are on Medicare, or receiving Social Security Disability but are not yet eligible for Medicare, it is not necessary to document citizenship or identity.
- **Race/Ethnic Group.** This information is optional and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race or ethnic background. You may pick more than one.

## SECTION C Family Income (Money Received)

- In this section, list all types of income (money received) and the amounts received by the people you listed in Section B.
- Please tell us how much you make before taxes are taken out.
- If there is no money coming into your home, explain how you are paying for your living expenses, such as food and housing.
- We need to know if you have changed jobs or if you are a student.
- We also need to know if you pay another person or place, such as a day care center, to take care of your children or disabled spouse or parent while you are working or going to school. If you do, we need to know how much you pay. We may be able to deduct some of the amount that you pay for these costs from the amount we count as your income.

## SECTION D Health Insurance

It is important to tell us whether anyone applying is covered or could be covered by someone else's health insurance. For some applicants, we can deduct the amount that you pay for health insurance from the amount we count as your income; or we may be able to pay the cost of your health insurance premium if we determine it is cost effective. We may be able to help pay for health insurance premiums if you have or can get insurance through your job. We will need to gather more information about the insurance and will mail an insurance questionnaire to you.

## SECTION E Housing Expenses

Write in your monthly cost of housing. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes in the mortgage amount you tell us. If you share your housing expenses or your rent is subsidized, please only tell us how much YOU pay toward your rent or mortgage. If you pay for your water, tell us how much you pay and how often.

## SECTION F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for each applicant, and what services may be needed. A person with a disability, serious illness or high medical bills may be able to get more health services. You may have a disability if your daily activities are limited because of an illness or condition that has lasted or is expected to last for at least 12 months. If you are blind, disabled, chronically ill or need nursing home care, you will need to complete Supplement A. If neither you nor anyone applying is blind, disabled, chronically ill or in a nursing home, go to Section G.

## SECTION G Additional Health Questions

If you have paid or unpaid medical bills from the past three months, Medicaid may be able to pay for these costs. Let us know who these bills are for and in which months the bills were incurred. Include copies of the medical bills with this application. Note: This three-month period begins when the local department of social services receives your application or when you meet with an Assistor to apply. You will need to tell us what your income was for any past months in which you have medical bills so that we can see if you are eligible during that time. We also ask about where you lived in the past three months, because this may affect our ability to pay for past bills. We ask about any pending lawsuits or health issues caused by someone else so we know if someone else should pay for any portion of your medical care costs.

If you are turning 65 within the next three months or you are 65 years of age or older, you may be entitled to additional medical benefits through the Medicare program. You are required to apply for Medicare as a condition of eligibility for Medicaid. Medicare is a federal health insurance program for people who are 65 or older and for certain people with disabilities regardless of income. When a person has both Medicare and Medicaid, Medicare pays first and Medicaid pays second. You are required to apply for Medicare if:

- You have Chronic Renal Failure (End Stage Renal Disease/ESRD) or Amyotrophic Lateral Sclerosis (ALS); **OR**
- You are turning 65 in the next three months or are already age 65 or older **AND** your income is at or below 120% of the federal poverty level (based on the family size for a single individual or married couple), or is at the Medicaid standard. If so, then the Medicaid program can pay your premium or reimburse your Medicare premiums. If the Medicaid program can pay or

reimburse your premiums, you will be required to apply for Medicare as a condition of Medicaid eligibility. Only citizens and lawful permanent residents who have lived in the U.S. continuously for five years must apply for Medicare. Many immigrants and non-citizens are not required to apply for Medicare.

## SECTION H Parent or Spouse Not Living in the Family or Deceased

- **If any applicants have an absent spouse or parent, you must complete this section so we can see if medical support is available to you or your child.**
- **If you are pregnant, you do not have to answer these questions until 60 days after the birth of your child.** All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. An example of "good cause" is fear of physical or emotional harm to you or a family member. Question 2 refers to the **PARENT** of any applying child under age 21. Question 3 refers to the **SPOUSE** of anyone applying.
- **If the applying parent** is not willing to provide this information, the applying child may still be eligible for Medicaid.

## SECTION I Health Plan Selection

**What is a Health Plan?** If you are found eligible for Medicaid, you may be required to get your health care coverage through a Managed Care health plan. A Managed Care health plan will provide your care by working with a network of doctors, clinics, hospitals and pharmacies to provide its members with high quality health care. When you join a plan, you choose one doctor (Primary Care Provider or PCP) from that plan to take care of your regular health and medical needs. If you want to keep the doctor you have, you need to pick a plan that works with your doctor. Managed Care health plans focus on preventive care so that small problems do not become big ones. If you need a specialist, your PCP can refer you to one in your plan's network.

**Who Must Choose a Health Plan? MOST** people who are eligible for Medicaid **MUST** choose a health plan to get most of their Medicaid benefits. Keep reading to find out how to get more information on this.

**How Do I Know What Health Plan to Choose and If I Can Enroll?**
For Medicaid, if you want to find out more about how managed care plans work, if you have to join, and how to choose a plan, call **Medicaid CHOICE** at **1-800-505-5678,** or call or visit your local department of social services. Ask for a Managed Care Education Packet. Information about health plans is also on the NYS Department of Health website at **www.health.ny.gov.** You can also enroll by phone, by calling **1-800-505-5678.**

**NOTE:** If you or a family member are found eligible for Medicaid, and are an American Indian/ Alaska Native you are not required to join a health plan. You **will** still be enrolled in the health plan you choose, unless you check the box on the application that says you don't want to be enrolled, or tell us you do not want to be enrolled by calling or writing to your local department of social services.

## SECTION J Signature

Please read the paragraph in this section carefully and read the **Terms, Rights and Responsibilities** section. You must then sign and date the application. Remember to send the application to the local department of social services in the county in which you reside.

# DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

**Applicant Name** sf **Application Date** 04/09/2025

*** Your enrollment cannot be completed until all NECESSARY items are received.** If you need help getting any of these items, let us know.
YOU DO NOT NEED TO SHOW US **ALL** OF THESE DOCUMENTS. We only need documents that apply to you or others who are applying. If we are unable to verify your U.S. Citizenship and identity electronically through federal databases, we will need to see documentation of U.S. Citizenship and identity. Please do not mail original U.S. Citizenship or identity documents. Copies of other documents needed to determine eligibility can be mailed with your application or dropped off at your local department of social services. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring documents.

**You need to provide proof of Identity, U.S. Citizenship and/or Immigration Status and Date of Birth.**

You can provide ONE of the following documents to prove both U.S. Citizenship, Identity and your Date of Birth:

- ☐ U.S. passport/card
- ☐ Certificate of Naturalization (DHS Forms N-550 or N-570)
- ☐ Certificate of U.S Citizenship (DHS Forms N-560 or N-561)
- ☐ NYS Enhanced Driver's License (EDL).
- ☐ Native American Tribal Document issued by a Federally Recognized Tribe

When none of the above documents are available, ONE document from the U.S. Citizenship list and ONE from the Identity list may be used to prove your citizenship and /or identity.
This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

**Documents with * next to it also show date of birth**

**U.S. Citizenship** (Provide One)

- ☐ U.S. Birth Certificate*
- ☐ Certification of Birth issued by Department of State (Forms FS-545 or DS-1350)*
- ☐ Report of Birth Abroad (FS-240)
- ☐ U.S. National ID card (Form I-197 or I-179)
- ☐ Religious/School Records*
- ☐ Military record of service showing U.S. place of birth
- ☐ Final adoption decree
- ☐ Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000

**AND**

**Identity** (Provide One)

- ☐ State Driver's license or ID card with photo*
- ☐ ID card issued by a federal, state, or local government agency
- ☐ U.S. Military card or draft record or U.S Coast Guard Merchant Mariner Card
- ☐ School ID card with a photo (may also show date of birth)
- ☐ Certificate of Degree of Indian blood or other American Indian/Alaska Native tribal document with photo
- ☐ Verified School, Nursery or Daycare records (for children under 18) (may also show date of birth)
- ☐ Clinic, Doctor or Hospital records (for children under 18)*

**If you do not have one of the documents that show your date of birth, you must also submit one of the following items:**

- ☐ Marriage certificate
- ☐ NYS Benefit Identification Card

***Please return all necessary documents by:** _____ **or application may be denied.**

# DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

## If you are not a U.S. Citizen

The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status.
This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

We need to see **ONE** of the following documents to prove Immigration Status, Identity and your Date of Birth. You must prove all three.
**Documents with * next to it also show date of birth**

**Immigration Status/Identity**

- ☐ I-551 Permanent Resident Card ("Green Card")*
- ☐ I-688B or I-766 Employment Authorization Card*

**Immigration Status, but require an additional Identity document**

- ☐ I-94 Arrival/Departure Record*
- ☐ USCIS Form I-797 Notice of Action

**DOB/Identity, but require an additional immigration status document**

- ☐ Visa
- ☐ U.S. Passport

## Home Address: This address must match the home address that you write in Section A of the application. The proof must be dated within 6 months of when you signed the application.

- ☐ Lease/ letter/ rent receipt with your home address from landlord
- ☐ Utility Bill (gas, electric, phone, cable, fuel or water)
- ☐ Property tax records or mortgage statement
- ☐ Driver's license (if issued in the past 6 months)
- ☐ Government ID card with address
- ☐ Postmarked envelope or post card (cannot use if sent to a P.O. Box)

## PROOF OF CURRENT INCOME, OR INCOME YOU MIGHT GET IN THE FUTURE SUCH AS UNEMPLOYMENT BENEFITS OR A LAWSUIT: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS, only the ones that apply to you and the people living with you.

**One proof for each type of income you have is required. Provide the most recent proof of income before taxes and any other deductions. The proof must be dated, include the employee's name and show gross income for the pay period. The proof must be for the last four weeks, whether you get paid weekly, bi-weekly, or monthly. It is important that these be current.**

**Wages and Salary**

- ☐ Paycheck stubs
- ☐ Letter from employer on company letterhead, signed and dated
- ☐ Business/payroll records

**Self-Employment**

- ☐ Current signed and dated income tax return and all Schedules
- ☐ Records of earnings and expenses/ business records

**Unemployment Benefits**

- ☐ Award letter/certificate
- ☐ Monthly benefit statement from NYS Department of Labor
- ☐ Printout of recipient's account information from the NYS Department of Labor's website (www.labor.ny.gov)
- ☐ Copy of Direct Payment Card with printout
- ☐ Correspondence from the NYS Department of Labor

**Private Pensions/Annuities**

- ☐ Statement from pension/annuity

**Social Security**

- ☐ Award letter/certificate
- ☐ Annual benefit statement
- ☐ Correspondence from Social Security Administration

**Workers' Compensation**

- ☐ Award letter
- ☐ Check stub

**Child Support/Alimony**

- ☐ Letter from person providing support
- ☐ Letter from court
- ☐ Child support/alimony check stub
- ☐ Copy of NY EPPICard with printout
- ☐ Copy of child support account information from **www.childsupport.ny.gov**
- ☐ Copy of bank statement showing direct deposit

**Veterans' Benefits**

- ☐ Award letter
- ☐ Benefit check stub
- ☐ Correspondence from Veterans Affairs

**Military Pay**

- ☐ Award letter
- ☐ Check stub

**Income from Rent or Room/Board**

- ☐ Letter from roomer, boarder, tenant
- ☐ Check stub

**Interest/Dividends/Royalties**

- ☐ Recent statement from bank, credit union or financial institution
- ☐ Letter from broker
- ☐ Letter from agent
- ☐ 1099 or tax return (if no other documentation is available)

# DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

### If you pay to have care for your children or an adult in your family while you work, provide one of the following:

- ☐ Written statement from day care center or other child/adult care provider
- ☐ Canceled checks or receipts that show your payments

### If you or your spouse are required to pay court ordered support you must provide the following:

- ☐ Court Order

### Proof of health insurance, provide all that apply:

- ☐ Proof of current insurance (Insurance policy, Certificate of Insurance or Insurance Card)
- ☐ Health Insurance Termination Letter
- ☐ Medicare Card (Red, White and Blue Card)
- ☐ Confirmation of Medicare Application
- ☐ Medicare Award or Denial Letter

### If you have medical bills in the last three months, provide all the following (if applicable):

For determination of eligibility for medical expenses from the past three months:

- ☐ Proof of income for the month(s) in which the expense was incurred
- ☐ Proof of residency/home address for the month(s) in which the expense was incurred, if different from the address listed in Section A of this application
- ☐ Medical bills for last three months, whether or not you paid them

### Resources (only if you are age 65 or older, certified blind or disabled and have no children under age 21 living with you):

- ☐ Bank account statements: checking, savings, retirement (IRA and Keogh)
- ☐ Stocks, bonds, certificates statements
- ☐ Copy of Life Insurance policy
- ☐ Copy of burial trust or fund burial plot deed or funeral agreement
- ☐ Deed for real estate other than residence

### Proof of Student Status for college students if employed:

- ☐ Copy of schedule
- ☐ Statement from college or university
- ☐ Other correspondence from college showing student status

# ACCESS NY HEALTH CARE Medicaid

Print clearly in blue or black ink. An incomplete application cannot be processed and will result in a delay of a decision on your application.

## SECTION A Applicant's Information

Please tell us who you are and how to contact you.

| Legal First Name | Middle Initial | Legal Last Name |
|---|---|---|
| dgh | test | ing |

**Primary Phone #** 2345 ☑ Home ☐ Cell ☐ Work ☐ Other

**Another Phone #** 1345 ☐ Home ☑ Cell ☐ Work ☐ Other

**What Language Do You:** Speak? spanish Read? spanish

| | | | | |
|---|---|---|---|---|
| **HOME ADDRESS** of the persons applying for health insurance **SEND PROOF** ☑ Check here if homeless | **Street** | | **Apt.#** | |
| | **City** | **State** | **Zip Code** | **County** |
| **MAILING ADDRESS** of the persons applying for health insurance if different from above. | **Street** ergt | | **Apt.#** srfcfsr | |
| | **City** secr | | **State** ecare | **Zip Code** ecrsfe |
| **OPTIONAL:** If there is another person you would like to receive your Medicaid notices, please provide this person's contact information. I want this contact person to: Check all that apply ☑ Apply for and/or renew Medicaid for me ☑ Discuss my Medicaid application or case, if needed ☑ Get notices and correspondence | **Name** scer | | **State** esrfer | |
| | **Street** ercfes | | **Apt.#** sdfghsrt | **Zip Code** sdfbsdf |
| | **City** asercf | | **Phone #** 132453 ☐ Home ☐ Work ☐ Cell ☐ Other | |

# Important Notice
# Options Available to Applicants Who May Be Blind or Visually Impaired

If you are blind or visually impaired and require information in an alternative format, check the type of mail you want to receive from us. Please return this form with your application.

- ☑ Standard notice and large print notice
- ☐ Standard notice and data CD notice Standard notice and audio CD notice
- ☐ Standard notice and braille notice, if you assert that none of the other alternative formats will be equally effective for you
- ☐ If you require another accommodation, please contact your social services district.

**APPLICATIONS FOR BENEFITS ADMINISTERED BY THE NEW YORK STATE MEDICAID PROGRAM (INCLUDING THE MEDICARE SAVINGS PROGRAM AND THE FAMILY PLANNING BENEFIT PROGRAM) ARE AVAILABLE IN LARGE PRINT AND DATA FORMATS. AUDIO AND BRAILLE VERSIONS OF THE APPLICATIONS ARE AVAILABLE FOR INFORMATIONAL PURPOSES ONLY.**

## SECTION B Family Information

If you live in the family, start with yourself. If you do not, start with any adults who live in the family. List the full legal names of the persons applying for or already receiving Medicaid **and list the ID Number from their Benefit Card or health plan ID card.** You **must** provide information for family members including: parents, step-parents, and spouses. You may provide information for other family members (for example, a dependent child under the age of 21). **Listing other family members may allow us to give you a higher eligibility level. Applicants who are pregnant or under age 19 may be eligible for insurance regardless of immigration status.** New York State ensures your right to access State benefits and/or services regardless of your sex, gender identity, or expression. If you would like to provide us with how you or your household members currently identify, please also select gender identity.

| | Name / Birth / Sex | Date of Birth SEND PROOF *Sex | **Gender Identity (optional) | Is this person applying for health insurance? | Is this person pregnant? | Is this person the parent of an applying child? | What is the relationship to the person in Box 1? | If this person has or had public health coverage in the past, check the box that applies. | Social Security Number (if you have one) | Please mark one box that indicates your current Citizenship or Immigration Status. SEND PROOF | †Race/ Ethnic Group | ††Received a service from the IHS, or other Indian Health Program? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | test ertyru ing<br>Legal First, Middle, Last Name<br>erft vd rcehry<br>This person's birth name before they were married<br>City<br>State of Birth / Country of Birth | 12/12/1974<br>☐ Male<br>☑ Female | ☐ Male<br>☐ Female<br>☐ Non-Binary/ Non-Conforming<br>☐ X<br>☐ Transgender<br>☐ Different Identity<br>Describe your identity (optional).<br>sgdf | ☑ Yes<br>☐ No | ☐ Yes<br>☑ No<br>What is the due date?<br>__/__/__ | ☑ Yes<br>☐ No | SELF | ☐ Child Health Plus<br>☑ Medicaid<br>☐ Family Health Plus<br>ID Number from Benefit Card/Plan Card, if known:<br>2134 | 1234 | ☐ U.S. Citizen<br>☑ Immigrant/non-citizen<br>Enter the date you received your immigration status<br>12 / 12 / 2004<br>MM DD YYYY<br>☐ Non-immigrant (Visa holder)<br>☐ None of the above | f | ☐ Yes<br>☑ No |
| 2 | sad cad sa<br>Legal First, Middle, Last Name<br>asd asdc asdv<br>This person's birth name before they were married<br>City<br>State of Birth / Country of Birth | 1/1/2002<br>☑ Male<br>☐ Female | ☐ Male<br>☐ Female<br>☐ Non-Binary/ Non-Conforming<br>☐ X<br>☐ Transgender<br>☐ Different Identity<br>Describe your identity (optional). | ☐ Yes<br>☑ No | ☐ Yes<br>☑ No<br>What is the due date?<br>__/__/__ | ☐ Yes<br>☑ No | | ☐ Child Health Plus<br>☐ Medicaid<br>☐ Family Health Plus<br>ID Number from Benefit Card/Plan Card, if known: | | ☐ U.S. Citizen<br>☐ Immigrant/non-citizen<br>Enter the date you received your immigration status<br>___/___/___<br>MM DD YYYY<br>☐ Non-immigrant (Visa holder)<br>☐ None of the above | | ☐ Yes<br>☐ No |

**SEND PROOF** Refer to the "Documents Needed When You Apply for Health Insurance" on pages 4-6, for a list of documents that prove Identity, Citizenship or Immigration Status.

*Sex: The sex you report here must be the same as what is currently on file with the Social Security Administration. The sex you report here is for our computer system's use only and will not appear on your benefit card or any other public-facing document. This is needed to process your application. If you identify differently you can add that information in the Gender Identity field 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.

†Race/Ethnic Group Codes (optional): **A** - Asian, **B** - Black or African-American, **I**- American Indian or Alaska Native, **P** - Native Hawaiian or other Pacific Islander, **W** - White, **U** - Unknown. Please also tell us if you are Hispanic or Latino - **H.**

††Have you ever received a service from the Indian Health Service (IHS), a Tribal Health Program, an Urban Indian Health Program or through a referral from IHS or one of these programs?

## SECTION B | Family Information

Continued from previous page

| | | Date of Birth **SEND PROOF** *Sex | **Gender Identity (optional) | Is this person applying for health insurance? | Is this person pregnant? | Is this person the parent of an applying child? | What is the relationship to the person in Box 1? | If this person has or had public health coverage in the past, check the box that applies. | Social Security Number (if you have one) | Please mark one box that indicates your current Citizenship or Immigration Status. **SEND PROOF** | †Race/ Ethnic Group | ††Received a service from the IHS, or other Indian Health Program? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | Legal First, Middle, Last Name<br>This person's birth name before they were married<br>City<br>State of Birth Country of Birth | __/__/____<br>☐ Male<br>☐ Female | ☐ Male<br>☐ Female<br>☐ Non-Binary/ Non-Conforming<br>☐ X<br>☐ Transgender<br>☐ Different Identity<br>Describe your identity (optional). | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No<br>What is the due date?<br>__/__/__ | ☐ Yes<br>☐ No | | ☐ Child Health Plus<br>☐ Medicaid<br>☐ Family Health Plus<br>ID Number from Benefit Card/Plan Card, if known: | | ☐ U.S. Citizen<br>☐ Immigrant/non-citizen<br>Enter the date you received your immigration status<br>_____/_____/_____<br>MM DD YYYY<br>☐ Non-immigrant (Visa holder)<br>☐ None of the above | | ☐ Yes<br>☐ No |
| 4 | Legal First, Middle, Last Name<br>This person's birth name before they were married<br>City<br>State of Birth Country of Birth | __/__/____<br>☐ Male<br>☐ Female | ☐ Male<br>☐ Female<br>☐ Non-Binary/ Non-Conforming<br>☐ X<br>☐ Transgender<br>☐ Different Identity<br>Describe your identity (optional). | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No<br>What is the due date?<br>__/__/__ | ☐ Yes<br>☐ No | | ☐ Child Health Plus<br>☐ Medicaid<br>☐ Family Health Plus<br>ID Number from Benefit Card/Plan Card, if known: | | ☐ U.S. Citizen<br>☐ Immigrant/non-citizen<br>Enter the date you received your immigration status<br>_____/_____/_____<br>MM DD YYYY<br>☐ Non-immigrant (Visa holder)<br>☐ None of the above | | ☐ Yes<br>☐ No |
| 5 | Legal First, Middle, Last Name<br>This person's birth name before they were married<br>City<br>State of Birth Country of Birth | __/__/____<br>☐ Male<br>☐ Female | ☐ Male<br>☐ Female<br>☐ Non-Binary/ Non-Conforming<br>☐ X<br>☐ Transgender<br>☐ Different Identity<br>Describe your identity (optional). | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No<br>What is the due date?<br>__/__/__ | ☐ Yes<br>☐ No | | ☐ Child Health Plus<br>☐ Medicaid<br>☐ Family Health Plus<br>ID Number from Benefit Card/Plan Card, if known: | | ☐ U.S. Citizen<br>☐ Immigrant/non-citizen<br>Enter the date you received your immigration status<br>_____/_____/_____<br>MM DD YYYY<br>☐ Non-immigrant (Visa holder)<br>☐ None of the above | | ☐ Yes<br>☐ No |

Is anyone in your household a veteran? ☐ Yes ☐ No If yes, name: _____

**SEND PROOF** Refer to the "Documents Needed When You Apply for Health Insurance" on pages 4-6, for a list of documents that prove Identity, Citizenship or Immigration Status.

*Sex: The sex you report here must be the same as what is currently on file with the Social Security Administration. The sex you report here is for our computer system's use only and will not appear on your benefit card or any other public-facing document. This is needed to process your application. If you identify differently you can add that information in the Gender Identity field 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.

†Race/Ethnic Group Codes (optional): **A** - Asian, **B** - Black or African-American, **I**- American Indian or Alaska Native, **P** - Native Hawaiian or other Pacific Islander, **W** - White, **U** - Unknown. Please also tell us if you are Hispanic or Latino - **H.**

††Have you ever received a service from the Indian Health Service (IHS), a Tribal Health Program, an Urban Indian Health Program or through a referral from IHS or one of these programs?

## SECTION C | Family Income

Write the types of money and the amount received by everyone listed in Section B and **SEND PROOF**

**Earnings from Work:** Includes wages, salaries, commissions, tips, overtime, self-employment. If you are self-employed, check here: ☐ If no earnings from work, check here: ☑

| Name of Person | Type of Income/Employer Name | How Much? (before taxes) | How Often? (weekly, monthly) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Unearned Income:** Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veterans' benefits, Workers' Compensation, child support payments/alimony, rental income, pension, annuities and trust income. If no unearned income, check here: ☐

| Name of Person | Type of Income/Source | How Much? (before taxes) | How Often? (weekly, monthly) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Contributions:** Money from relations or friends, roomers or boarders (include money that anyone gives you each month to help meet living expenses). If no contributions, check here: ☐

| Name of Person | Type of Income/Source | How Much? (before taxes) | How Often? (weekly, monthly) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Other:** Temporary (cash) Assistance, Supplemental Security Income (SSI) payments, student grants, or loans. If none, check here: ☐

| Name of Person | Type of Income/Source | How Much? (before taxes) | How Often? (weekly, monthly) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

If you or any applying adult in Section B does not have income, tell us who?

1. If there is no income listed above, please explain how you are living: (For example: living with friend or relative)

2. Have you or anyone who is applying changed jobs or stopped working in the last 3 months? ☐ No ☐ Yes
   If yes: Your last job was: Date / / Name of Employer:

3. Are you or anyone who is applying a student in a vocational, undergraduate, or graduate program? ☐ No ☐ Yes
   If yes: ☐ Full Time ☐ Part Time ☐ Undergraduate ☐ Graduate Name of Student: _____

4. Do you have to pay for childcare (or for the care of a disabled adult) in order to work or go to school? ☐ No ☐ Yes

| Child's/Adult's Name: | How Much? $ | How Often? (weekly, every two weeks, monthly) |
|---|---|---|
| Child's/Adult's Name: | How Much? $ | How Often? (weekly, every two weeks, monthly) |
| Child's/Adult's Name: | How Much? $ | How Often? (weekly, every two weeks, monthly) |

5. If you are not eligible for Medicaid coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only? ☐ No ☐ Yes

6. Are you or your spouse / other parent required to pay court ordered support? ☐ No ☐ Yes Who How Much? $

## SECTION D Health Insurance

You and your family may still be eligible even if you have other health insurance.

1. Does anyone who is applying have Medicare? ☐ No ☐ Yes
   **SEND PROOF**

   If yes, include a copy of your card (red, white and blue card), for each Medicare beneficiary. Complete the rest of this application and complete Supplement A.

   If no, and you have Chronic Renal Failure (End Stage Renal Disease/ESRD) or Amyotrophic Lateral Sclerosis (ALS),or you are 65 years of age or older, or turning age 65 within three months, and do not have Medicare, you must apply for Medicare and show proof of application. Some people are required to apply for MEDICARE as a condition of eligibility for Medicaid.
   Please reference pages 2 and 3 ( Section G ) for additional information regarding eligibility requirements.

Note: If you are applying for the Medicare Savings Program (MSP) only, go to Section G. You do NOT need to complete Supplement A.

2. Does anyone who is applying already have other commercial health insurance, including long term care insurance? ☐ No ☐ Yes
   **SEND PROOF**

   If yes, you must send a copy of the front and back of the insurance card with this application.

   Name of Insured (primary):

   Persons Covered:

   Cost of Policy:

   End date of coverage, if ending soon _____ / _____ / _____
   Month Day Year

3. Does your current job offer health insurance? ☑ No ☐ Yes
   **We may be able to help pay for it.**

   If yes, a "Request for Information Employer Sponsored Health Insurance" form will be sent to you.

## SECTION E Housing Expenses

1. Monthly housing payment such as rent or mortgage, including property taxes (just your share) $

2. If you pay for water separately how much do you pay? $ **SEND PROOF**

   How often do you pay? ☐ every month ☐ 2 times a year ☐ quarterly (4 times a year) ☐ once a year

3. Do you receive free housing as part of your pay? ☐ No ☐ Yes

## SECTION F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for the applicants.

**If no one is Blind, Disabled, Chronically Ill or in a Nursing Home STOP please go to Section G.**

1. Are you, or anyone who lives with you and is applying, in a residential treatment facility or receiving nursing home care in a hospital, nursing home or other medical institution? ☐ No ☐ Yes

   If yes, finish completing this application AND complete Supplement A.

2. Are you or anyone who lives with you blind, disabled or chronically ill? ☐ No ☐ Yes

   If yes, finish completing this application AND complete Supplement A.

Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do not need to complete Supplement A.

## SECTION G Additional Health Questions

1. Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you. ☐ No ☐ Yes
   If yes, name:
   In which month(s) of the previous three months do you have medical bills?

   **SEND PROOF of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and proof of payment.**

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? ☐ No ☐ Yes

3. Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months? ☐ No ☐ Yes
   If yes, who?
   Which state?
   Which county?

4. Does anyone who is applying have a pending lawsuit due to an injury? ☐ No ☐ Yes If yes, who?

5. Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)? ☐ No ☐ Yes If yes, who?

## SECTION H Parent or Spouse Not Living in the Family or Deceased

Pregnant applicants and families who are applying only for their children are NOT required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information. If you fear physical or emotional harm as a result of providing information about a parent or spouse not living in the home, you may be excused from providing this information. This is called **Good Cause.** You may be asked to show that you have a good reason for your fears.

1. Is the spouse or parent of anyone applying deceased? (If spouse or parent is deceased go to question 3.) ☐ No ☐ Yes If yes, name of applicant with deceased parent or spouse

2. Does a parent of any applying child live outside the home? (If no, skip to question 3) ☐ No ☐ Yes

   If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box ☐.

| **Child's Name:** | **Name of parent living outside the home** | **Current or last known address:** |
|---|---|---|
| | | Street: City/State: |
| | Date of Birth (if known): / / | SSN (if known): |
| **Child's Name:** | **Name of parent living outside the home** | **Current or last known address:** |
| | | Street: City/State: |
| | Date of Birth (if known): / / | SSN (if known): |

3. Is anyone applying still married to someone who lives outside the home? ☐ No ☐ Yes If yes, name of person applying who is still married:

   If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box ☐

| **Legal name of spouse living outside of the home:** | | **Current or last known address:** |
|---|---|---|
| | | Street: City/State: |
| | Date of Birth (if known): / / | SSN (if known): |

## SECTION I Health Plan Selection

These questions help us determine which program is best for the applicants

**If you are in receipt of Medicare, STOP skip this section.**

IMPORTANT: Most people with Medicaid must choose a health plan; if you don't choose a health plan you may be automatically enrolled in one unless it is determined you are exempt. If you need information about what plans are available in your county, what plans your doctor is in and if you have to join, please call New York Medicaid CHOICE at 1-800-505-5678. You can also call or visit your local department of social services. If you already know what plan you want, use this section for your plan choice.

NOTE: If you or family members are found eligible for Medicaid, you will be enrolled in the health plan you choose. If you are an American Indian/Alaska Native you are not required to join a health plan; you can tell us you do not want to be in a health plan by calling or writing to your local department of social services or by checking this box ☐.

| Legal Last Name | Legal First Name | Date of Birth | Social Security # | Name of Health Plan You are Enrolling in | Preferred Doctor or Health Center (optional) Check Box if Your Current Provider | OB/GYN (optional) |
|---|---|---|---|---|---|---|
| | | | | | ☐ | |
| | | | | | ☐ | |
| | | | | | ☐ | |
| | | | | | ☐ | |
| | | | | | ☐ | |
| | | | | | ☐ | |

## SECTION J Signature

I agree to have the information on this application and on the annual renewal shared only among Medicaid, the health plans indicated in Section I, the local department of social services, and the organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Medicaid, or to evaluate the success of these programs. Each applying adult must sign this application in the space below.

**I have read and understand the Terms, Rights and Responsibilities included in this application booklet on the next page. I certify under penalty of perjury that everything on this application is the truth as best I know.**

| Date | Signature of adult applicant or authorized representative for the applicant |
|---|---|
| Date | Signature of adult applicant or authorized representative for the applicant |

## Health Care Proxy

The New York Health Care Proxy Law allows you to choose someone you trust to make health care decisions for you if you can't make them for yourself. This person is called a health care agent.
You can learn more about the New York State Health Care Proxy Law and get the form for a health care agent (proxy form) on the New York State Department of Health website at:
www.health.ny.gov/professionals/patients/health_care_proxy

To get a copy of the form mailed to you, call the New York State Medicaid Help Line at 1-800-541-2831.

# TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid. I understand that this application 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 local department of social services. The local department of social services may be able to help in getting the information.
- If I am applying at a place other than a local department of social services, and my children are not found eligible for Medicaid using this application, I can contact the local department of social services to see if my children are eligible for Medicaid on some other basis.
- I understand that workers from the programs, for which family members or 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 agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.
- I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. 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 Medicaid will not be affected by my race, color, or national origin. I also understand that depending on the requirements of the program, my age, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that if my child is on Medicaid, they can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the local department of social services.
- 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. The New York State Department of Tax and Finance has the right to review income information on this form.

## Social Security Number (SSNs)

SSNs are required for all applicants, unless the person is a non-qualified non-citizen. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are not required for members of my family who are not applying for benefits. If my eligibility depends on the amount of resources owned by my spouse, resources can be verified if my spouse's SSN is provided. SSNs are used in many ways, both within local department of social services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for their child(ren), to see if applicants can get medical support, to see if applicants can get money or other help, and to verify resources for applicants and their non-applying spouse. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient.

## For Medicaid Applicants Only

- Release of Educational Records
  I give permission to the local department of social services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.
- Early Intervention Program
  If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local department of social services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.
- Reimbursement of Medical Expenses
  I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application and ending on the date I receive my Medicaid benefit card (Common Benefit Identification Card (CBIC)), I understand that reimbursement of medically necessary covered medical care, services and supplies will **only** be available if obtained from Medicaid enrolled providers and that reimbursement is limited to no more than the Medicaid rate or fee in effect at the time of service, even if I paid more. I understand that once I receive my Medicaid (CBIC) benefit card, I must visit only Medicaid enrolled providers or network providers of my Medicaid managed care plan to obtain covered care and services, that my provider must submit a claim to Medicaid or my Medicaid managed care plan to be paid for medically necessary services and that no reimbursement will be made for expenses I incur after that date and pay for myself.

## Medicaid Managed Care

I have read how to find out what Medicaid managed care health plans are available to me in my county. I understand that if I, and any members of my family who are applying, are found eligible for Medicaid and are required to be in a managed care health plan, I and any eligible family members who applied, will be enrolled in the health plan I choose.

I have read how to find out the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership. I understand that in Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three PCPs in my health plan. I understand that once I enroll in a health plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances.

I understand that if a child is born to me while I am a member of a Medicaid managed care health plan, my child will be enrolled in the same health plan that I am in.

**Release of Medical Information**

I consent to the release of any medical information about me and any members of my family for whom I can give consent:

- By my PCP, any other health care provider or the New York State Department of Health (NYSDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
- By my health plan and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid programs; and
- By my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations.

I also agree that the information released for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent.

If more than one adult in the family is joining a Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

## Notice of Nondiscrimination Policy

The New York Medicaid program complies with applicable Federal civil rights laws and state laws and does not discriminate on the basis of race, color, national origin, creed/religion, sex, age, marital/family status, disability, arrest record, criminal conviction(s), gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic violence victim status and/or retaliation.

If you believe that the New York Medicaid program has discriminated against you, you may file a complaint by going to: http://www.health.ny.gov/regulations/discrimination_complaints/ or, by emailing the Diversity Management Office at DMO@health.ny.gov.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 800-368-1019 (TTY 800-537-7697). Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

## Accommodations

The New York Medicaid program provides free aid and services to people with disabilities to communicate effectively with us,
such as:

- TTY through NY Relay Service
- If you are blind or seriously visually impaired and need notices or other written materials in an alternative format (large print, audio, or data CD, or Braille), and you reside in a county outside of New York City, please call your local department of social services. If you reside in the five boroughs of New York City, please call the Human Resources Administration's Office of Constituent Services at 212-331-4640. Or tell us in Section A on page 1 of this application.

The NY Medicaid Program also provides free language assistance services to people whose primary language is not English such as:

- Qualified interpreters
- Written information in other languages

If you need these services or for more information on Reasonable Accommodations, and you reside in a county outside of New York City, please call your local department of social services. If you reside in the five boroughs of New York City, please call the Human Resources Administration's Office of Constituent Services at 212-331-4640.

## For Office Use Only

**To be completed by the person assisting with the application**

| Signature of Person Who Obtained Eligibility Information: | Employed By: (check one) ☐ Health Plan ☐ Local Department of Social Services ☐ Provider Agency ☐ Qualified Entities |
|---|---|
| X | Employer Name: |

**To be used by the local social services district**

| | | | | |
|---|---|---|---|---|
| Eligibility Determined By: | | Date: | Eligibility Approved By: | Date: |
| Center Office: | | Application Date: | Unit ID: | Worker ID: |
| Case Name: | District: | Case Type: | | Case #: |
| Effective Date: | MA Disposition Reason Code<br>☐ Denial Code ☐ Withdrawal Code | Proxy:<br>☐ No ☐ Yes | Registry #: | Ver: |