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# **MEDICAID APPLICATION**

## **Chronic Care / Nursing Home Coverage**

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### **APPLICANT**

**Firstname Lastname**

Resident at:

PLACE

Rehabilitation and Nursing Center,  
City, State

### **SUBMITTED BY**

Firstname Lastname (Daughter & Power of Attorney)

address

City, State zip

email

### **DATE OF SUBMISSION**

Month day, year

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# PART 1

## Forms & Identity

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[The county DSS mailed us a paper to sign.]

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## Authorization for Verification of Resources (Applicant)

This form authorizes Medicaid to request records from financial institutions for an individual applying for Medicaid.

This Authorization must be signed by the applicant if the applicant is:

- Age 65 or older
- Certified blind or certified disabled (of any age)

Please provide the information for the applicant below and sign the authorization.

Signing this Authorization is a condition of receiving Medicaid benefits. This is because eligibility depends on the amount of resources owned by the applicant. **Failure to sign and submit this Authorization may result in a denial or discontinuance of Medicaid benefits.**

### I. INFORMATION FOR APPLICANT

Applicant's Name	Last Name	First Name	Middle Initial
Social Security Number			
Date of Birth			
Date of Birth			
Date of Birth			

### II. AUTHORIZATION

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid.

This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I revoke this authorization in a written statement to my local Department of Social Services.

Signature of Applicant/Legal Representative\* \_\_\_\_\_

Date Signed \_\_\_\_\_

*\*Note: If a legal representative is signing this authorization, also include the legal document giving him/her authority to act on behalf of applicant.*

**COMPLETE THIS FORM IF SOMEONE OTHER THAN  
THE APPLICANT SIGNED THE MEDICAID APPLICATION**

If you are signing a Medicaid application on behalf of an applicant who is age 18 or older, complete **Sections A** through **C** and submit this form along with proof of authorization (if applicable). **Failure to submit this form and/or proof of authorization may result in a denial or discontinuance of Medicaid benefits.**

The authorization in **Section D** may be used by the applicant to allow you to apply for Medicaid on his/her behalf.

**SECTION A APPLICANT INFORMATION**

Applicant's Name	Last Name	First Name	Middle Initial
Social Security Number			
Social Security Number			
Social Security Number			
Date of Birth			
Date of Birth			
Date of Birth			

**SECTION B INFORMATION FOR PERSON SIGNING APPLICATION ON APPLICANT'S BEHALF**

Name of Person Signing Application	Last Name	First Name			
Relationship to Applicant		Phone			
Address	Number	Street	Apt. Number		
City	State	Zip Code			

*If a representative of a facility/company/agency is signing application, provide the following information:*

Name of Facility/Company/Agency					
Address	Number	Street	Suite Number		
City	State	Zip Code			
Name of Representative	Last Name	First Name			
Title		Phone			

## SECTION C REASON FOR SUBMISSION

**INSTRUCTIONS:** If you are signing a Medicaid application on behalf of the applicant, you must provide the authorization/legal document authorizing you to apply on the applicant's behalf **OR** attest that the applicant is incompetent or incapacitated. **Please check the appropriate boxes below. Attach the authorization (if applicable) to this form and sign and date below.**

- I have authorization to apply for Medicaid on behalf of the applicant.  
*(Check the box for the type of authorization you have and submit the authorization OR complete Section D below.)*
  - Guardianship Document
  - Power of Attorney (POA) Document
  - Other Written Authorization (Specify) \_\_\_\_\_
- I attest that the applicant is incompetent or incapacitated. S/he is unable to sign the application herself/himself and is unable to provide written consent for me to apply on his/her behalf.

Signature of Person Completing This Form \_\_\_\_\_

Date Signed \_\_\_\_\_

## SECTION D AUTHORIZATION TO APPLY FOR MEDICAID ON APPLICANT'S BEHALF

**INSTRUCTIONS:** If the applicant would like to provide the below authorization allowing you to represent him/her in applying for and/or renewing Medicaid, the applicant or his/her legal representative or spouse must sign the authorization below.

**NOTE:** If a legal representative is signing this authorization, also include the legal document giving him/her authority to act on behalf of applicant.

I authorize the person or the facility/company/agency named in **Section B** of this form to represent me in the Medicaid application and/or renewal process.

I authorize the release of necessary information/documentation between the local Department of Social Services/Medicaid Program and the person or facility/company/agency named in **Section B** in regard to my application and/or continuing eligibility.

Signature of Applicant/Legal Representative/Applicant's Spouse \_\_\_\_\_

Date Signed \_\_\_\_\_



## POWER OF ATTORNEY NEW YORK STATUTORY SHORT FORM

**(a) CAUTION TO THE PRINCIPAL:** Your Power of Attorney is an important document. As the “principal,” you give the person whom you choose (your “agent”) authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. “Important Information for the Agent” at the end of this document describes your agent’s responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to any third parties who may have acted upon it, including the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a “Health Care Proxy” to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, [www.senate.state.ny.us](http://www.senate.state.ny.us) or [www.assembly.state.ny.us](http://www.assembly.state.ny.us).

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

**(b) DESIGNATION OF AGENT(S):**

I, \_\_\_\_\_

*(name of principal)*

\_\_\_\_\_

*(address of principal)*

hereby appoint:

\_\_\_\_\_

*(name of agent)*

\_\_\_\_\_

*(address of agent)*

\_\_\_\_\_

*(name of second agent)*

\_\_\_\_\_

*(address of second agent)*

as my agent(s).



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If you designate more than one agent above, they must act together unless you initial the statement below.

( ) My agents may act SEPARATELY.

**(c) DESIGNATION OF SUCCESSOR AGENT(S): (OPTIONAL)**

If any agent designated above is unable or unwilling to serve, I appoint as my successor agent(s):

*(name of successor agent)*

*(address of successor agent)*

*(name of second successor agent),*

*(address of second successor agent)*

Successor agents designated above must act together unless you initial the statement below.

( ) My successor agents may act SEPARATELY.

You may provide for specific succession rules in this section. Insert specific succession provisions here:

**(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications".**

**(e) This POWER OF ATTORNEY DOES NOT REVOKE any Powers of Attorney previously executed by me unless I have stated otherwise below, under "Modifications".**

If you do NOT intend to revoke your prior Powers of Attorney, and if you have granted the same authority in this Power of Attorney as you granted to another agent in a prior Power of Attorney, each agent can act separately unless you indicate under "Modifications" that the agents with the same authority are to act together.

**(f) GRANT OF AUTHORITY:**

To grant your agent some or all of the authority below, either

- (1) Initial the bracket at each authority you grant, or
- (2) Write or type the letters for each authority you grant on the blank line at (P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

( ) (A) real estate transactions;

( ) (B) chattel and goods transactions;

( ) (C) bond, share, and commodity transactions;

( ) (D) banking transactions;

( ) (E) business operating transactions;

( ) (F) insurance transactions;



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- (G) estate transactions;
- (H) claims and litigation;
- (I) personal and family maintenance: If you grant your agent this authority, it will allow the agent to make gifts that you customarily have made to individuals, including the agent, and charitable organizations. The total amount of all such gifts in any one calendar year cannot exceed five hundred dollars;
- (J) benefits from governmental programs or civil or military service;
- (K) health care billing and payment matters; records, reports, and statements;
- (L) retirement benefit transactions;
- (M) tax matters;
- (N) all other matters;
- (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;
- (P) EACH of the matters identified by the following letters: \_\_\_\_\_.

You need not initial the other lines if you initial line (P).

**(g) MODIFICATIONS: (OPTIONAL)**

In this section, you may make additional provisions, including language to limit or supplement authority granted to your agent. However, you cannot use this Modifications section to grant your agent authority to make gifts or changes to interests in your property. If you wish to grant your agent such authority, you MUST complete the Statutory Gifts Rider.

**(h) CERTAIN GIFT TRANSACTIONS: STATUTORY GIFTS RIDER (OPTIONAL)**

In order to authorize your agent to make gifts in excess of an annual total of \$500 for all gifts described in (I) of the grant of authority section of this document (under personal and family maintenance), you must initial the statement below and execute a Statutory Gifts Rider at the same time as this instrument. Initialing the statement below by itself does not authorize your agent to make gifts. The preparation of the Statutory Gifts Rider should be supervised by a lawyer.

- (SGR) I grant my agent authority to make gifts in accordance with the terms and conditions of the Statutory Gifts Rider that supplements this Statutory Power of Attorney.

**(i) DESIGNATION OF MONITOR(S): (OPTIONAL)**

If you wish to appoint monitor(s), initial and fill in the section below:

I wish to designate \_\_\_\_\_, whose address(es) is (are) \_\_\_\_\_, as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

**(j) COMPENSATION OF AGENT(S): (OPTIONAL)**

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your



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behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, initial the statement below. If you wish to define "reasonable compensation", you may do so above, under "Modifications".

( ) My agent(s) shall be entitled to reasonable compensation for services rendered.

**(k) ACCEPTANCE BY THIRD PARTIES:**

I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

**(l) TERMINATION:**

This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.

Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

**(m) SIGNATURE AND ACKNOWLEDGMENT:**

In Witness Whereof I have hereunto signed my name on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

PRINCIPAL signs here: =====> \_\_\_\_\_

STATE OF NEW YORK        )  
                                )        ss:  
COUNTY OF \_\_\_\_\_ )

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

\_\_\_\_\_  
Notary Public

**(n) IMPORTANT INFORMATION FOR THE AGENT:**

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

- (1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;
- (2) avoid conflicts that would impair your ability to act in the principal's best interest;
- (3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;
- (4) keep a record of all receipts, payments, and transactions conducted for the principal; and



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- (5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manners: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or anyone else or make gifts to yourself or anyone else unless the principal has specifically granted you that authority in this document, which is either a Statutory Gifts Rider attached to a Statutory Short Form Power of Attorney or a Non-Statutory Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest.

You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

**Liability of agent:** The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

**(o) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:**

It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

I/we, \_\_\_\_\_, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

Agent(s) sign(s) here: ==> \_\_\_\_\_

==> \_\_\_\_\_

STATE OF NEW YORK )

) ss:

COUNTY OF \_\_\_\_\_ )

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

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Notary Public



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New York Statutory Short Form Power of Attorney, 8/18/10, Eff. 9/12/10

**(p) SUCCESSOR AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:**

It is not required that the principal and the SUCCESSOR agent(s), if any, sign at the same time, nor that multiple SUCCESSOR agents sign at the same time. Furthermore, successor agents can not use this power of attorney unless the agent(s) designated above is/are unable or unwilling to serve.

I/we, \_\_\_\_\_, have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as SUCCESSOR agent(s) for the principal named therein.

Successor Agent(s) sign(s) here: ==> \_\_\_\_\_

==> \_\_\_\_\_

STATE OF NEW YORK )

) ss:

COUNTY OF \_\_\_\_\_ )

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

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Notary Public



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Statutory Short Form Power of Attorney, Major Gifts Rider Authorization, 7/28/09

## **Power of Attorney New York Statutory Major Gifts Rider Authorization to Make Major Gifts or Other Transfers**

**CAUTION TO THE PRINCIPAL:** THIS OPTIONAL RIDER ALLOWS YOU TO AUTHORIZE YOUR AGENT TO MAKE MAJOR GIFTS OR OTHER TRANSFERS OF YOUR MONEY OR OTHER PROPERTY DURING YOUR LIFETIME. GRANTING ANY OF THE FOLLOWING AUTHORITY TO YOUR AGENT GIVES YOUR AGENT THE AUTHORITY TO TAKE ACTIONS WHICH COULD SIGNIFICANTLY REDUCE YOUR PROPERTY OR CHANGE HOW YOUR PROPERTY IS DISTRIBUTED AT YOUR DEATH. "MAJOR GIFTS OR OTHER TRANSFERS" ARE DESCRIBED IN SECTION 5-1514 OF THE GENERAL OBLIGATIONS LAW. THIS MAJOR GIFTS RIDER DOES NOT REQUIRE YOUR AGENT TO EXERCISE GRANTED AUTHORITY, BUT WHEN HE OR SHE EXERCISES THIS AUTHORITY, HE OR SHE MUST ACT ACCORDING TO ANY INSTRUCTIONS YOU PROVIDE, OR OTHERWISE IN YOUR BEST INTEREST.

**THIS MAJOR GIFTS RIDER AND THE POWER OF ATTORNEY IT SUPPLEMENTS MUST BE READ TOGETHER AS A SINGLE INSTRUMENT.**

**BEFORE SIGNING THIS DOCUMENT AUTHORIZING YOUR AGENT TO MAKE MAJOR GIFTS AND OTHER TRANSFERS, YOU SHOULD SEEK LEGAL ADVICE TO ENSURE THAT YOUR INTENTIONS ARE CLEARLY AND PROPERLY EXPRESSED.**

**(a) GRANT OF LIMITED AUTHORITY TO MAKE GIFTS**

GRANTING GIFTING AUTHORITY TO YOUR AGENT GIVES YOUR AGENT THE AUTHORITY TO TAKE ACTIONS WHICH COULD SIGNIFICANTLY REDUCE YOUR PROPERTY. IF YOU WISH TO ALLOW YOUR AGENT TO MAKE GIFTS TO HIMSELF OR HERSELF, YOU MUST SEPARATELY GRANT THAT AUTHORITY IN SUBDIVISION (C) BELOW.

TO GRANT YOUR AGENT THE GIFTING AUTHORITY PROVIDED BELOW, INITIAL THE BRACKET TO THE LEFT OF THE AUTHORITY.

I grant authority to my agent to make gifts to my spouse, children and more remote descendants, and parents, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. For gifts to my children and more remote descendants, and parents, the maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code. This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

**(b) MODIFICATIONS:**

**USE THIS SECTION IF YOU WISH TO AUTHORIZE GIFTS IN EXCESS OF THE ABOVE AMOUNT, GIFTS TO OTHER BENEFICIARIES OR OTHER TYPES OF TRANSFERS. GRANTING SUCH AUTHORITY TO YOUR AGENT GIVES YOUR AGENT THE AUTHORITY TO TAKE ACTIONS WHICH COULD SIGNIFICANTLY REDUCE YOUR PROPERTY AND/OR CHANGE HOW YOUR PROPERTY IS DISTRIBUTED AT YOUR DEATH. IF YOU WISH TO AUTHORIZE YOUR AGENT TO MAKE GIFTS OR TRANSFERS TO HIMSELF OR HERSELF, YOU MUST SEPARATELY GRANT THAT AUTHORITY IN SUBDIVISION (C) BELOW.**

I grant the following authority to my agent to make gifts or transfers pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest:

(c) GRANT OF SPECIFIC AUTHORITY FOR AN AGENT TO MAKE MAJOR GIFTS OR OTHER TRANSFERS TO HIMSELF OR HERSELF: (OPTIONAL)

IF YOU WISH TO AUTHORIZE YOUR AGENT TO MAKE GIFTS OR TRANSFERS TO HIMSELF OR HERSELF, YOU MUST GRANT THAT AUTHORITY IN THIS SECTION, INDICATING TO WHICH AGENT(S) THE AUTHORIZATION IS GRANTED, AND ANY LIMITATIONS AND GUIDELINES.

(     ) I grant specific authority for the following agent(s) to make the following major gifts or other transfers to himself or herself:

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This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(d) ACCEPTANCE BY THIRD PARTIES: I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Major Gifts Rider.

(e) SIGNATURE OF PRINCIPAL AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on \_\_\_\_\_, 20\_\_\_\_.

PRINCIPAL signs here:

---

STATE OF NEW YORK )

) ss.:

COUNTY OF \_\_\_\_\_)

On the \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_, before me, the undersigned, a Notary Public in and for said state, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the person or the entity upon behalf of which the person acted, executed the instrument.

---

[Notary Public]

(f) SIGNATURES OF WITNESSES:

By signing as a witness, I acknowledge that the principal signed the Major Gifts Rider in my presence and the presence of the other witness, or that the principal acknowledged to me that the principal's signature was affixed by him or her or at his or her direction. I also acknowledge that the principal has stated that this Major Gifts Rider reflects his or her wishes and that he or she has signed it voluntarily. I am not named herein as a permissible recipient of major gifts.

---

Signature of witness 1

---

Date

---

Print Name

---

Address

---

City, State, Zip code

---

Signature of witness 2

---

Date

---

Print Name

---

Address

---

City, State, Zip code

(g) This document prepared by: \_\_\_\_\_

2008 N.Y. Laws ch. 644, § 19, 5-1514; 2009 N.Y. Laws ch. 4 (amending effective date from March 1, 2009 to September 1, 2009).



# 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/lsss.htm](https://www.health.ny.gov/health_care/medicaid/lsss.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.

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 the Medicaid income level (based on the family size for a single individual or married couple). 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 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.



## SECTION H Parent or Spouse Not Living with 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](http://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 \_\_\_\_\_

Application Date \_\_\_\_\_

\* 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](http://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](http://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	
Primary Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other	Another Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other	What Language Do You: Speak? Read?	
HOME ADDRESS of the persons applying for health insurance <b>SEND PROOF</b> <input type="checkbox"/> 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	Apt.#
		City	State Zip Code
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:		Name	State
<input checked="" type="checkbox"/> Check all that apply <input type="checkbox"/> Apply for and/or renew Medicaid for me <input type="checkbox"/> Discuss my Medicaid application or case, if needed <input type="checkbox"/> Get notices and correspondence		Street	Apt.# Zip Code
		City	Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> 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.

- 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.**

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**SECTION B****Family Information**

If you live in the household, start with yourself. If you do not, start with any adults who live in the household. 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.

		Date of Birth <b>SEND PROOF</b> 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. <b>SEND PROOF</b>	Race/ Ethnic Group (Optional)	**Received a service from the IHS, or other Indian Health Program?	
1	Legal First, Middle, Last Name	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/ Non-Conforming <input type="checkbox"/> X <input type="checkbox"/> Transgender <input type="checkbox"/> Different Identity Describe your identity (optional).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the due date? ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	SELF	<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ MM DD YYYY <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above		<input type="checkbox"/> B - Black or African-American <input type="checkbox"/> I - American Indian or Alaska Native <input type="checkbox"/> W - White <input type="checkbox"/> U - Unknown <input type="checkbox"/> **A - Asian <input type="checkbox"/> **U - Native Hawaiian or other Pacific Islander *Other AAPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
	This person's birth name before they were married												
	City												
	State of Birth	Country of Birth											
2	Legal First, Middle, Last Name	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X <input type="checkbox"/> Transgender <input type="checkbox"/> Different Identity Describe your identity (optional).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the due date? ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ MM DD YYYY <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above		<input type="checkbox"/> B - Black or African-American <input type="checkbox"/> I - American Indian or Alaska Native <input type="checkbox"/> W - White <input type="checkbox"/> U - Unknown <input type="checkbox"/> **A - Asian <input type="checkbox"/> **U - Native Hawaiian or other Pacific Islander *Other AAPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
	This person's birth name before they were married												
	City												
	State of Birth	Country of Birth											

**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.

\*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.

\*\*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.

††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 <b>SEND PROOF</b> 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. <b>SEND PROOF</b>	Race/ Ethnic Group (Optional)	**Received a service from the IHS, or other Indian Health Program?
Legal First, Middle, Last Name	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/ Non-Conforming <input type="checkbox"/> X <input type="checkbox"/> Transgender <input type="checkbox"/> Different Identity Describe your identity (optional).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/_____ MM DD YYYY <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	<input type="checkbox"/> B - Black or African-American <input type="checkbox"/> I - American Indian or Alaska Native <input type="checkbox"/> W - White <input type="checkbox"/> U - Unknown <input type="checkbox"/> **A - Asian <input type="checkbox"/> **U - Native Hawaiian or other Pacific Islander *Other AAPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 This person's birth name before they were married											
City											
State of Birth	Country of Birth										
Legal First, Middle, Last Name	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/ Non-Conforming <input type="checkbox"/> X <input type="checkbox"/> Transgender <input type="checkbox"/> Different Identity Describe your identity (optional).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/_____ MM DD YYYY <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	<input type="checkbox"/> B - Black or African-American <input type="checkbox"/> I - American Indian or Alaska Native <input type="checkbox"/> W - White <input type="checkbox"/> U - Unknown <input type="checkbox"/> **A - Asian <input type="checkbox"/> **U - Native Hawaiian or other Pacific Islander *Other AAPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
4 This person's birth name before they were married											
City											
State of Birth	Country of Birth										
Legal First, Middle, Last Name	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary/ Non-Conforming <input type="checkbox"/> X <input type="checkbox"/> Transgender <input type="checkbox"/> Different Identity Describe your identity (optional).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/_____ MM DD YYYY <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	<input type="checkbox"/> B - Black or African-American <input type="checkbox"/> I - American Indian or Alaska Native <input type="checkbox"/> W - White <input type="checkbox"/> U - Unknown <input type="checkbox"/> **A - Asian <input type="checkbox"/> **U - Native Hawaiian or other Pacific Islander *Other AAPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
5 This person's birth name before they were married											
City											
State of Birth	Country of Birth										

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.

\*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.

\*\*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.

†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  Yes6. 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 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.

**SEND PROOF**

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

**SEND PROOF**

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 If yes, a "Request for Information Employer Sponsored Health Insurance" form will be sent to you.  
**We may be able to help pay for it.**

## 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.	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, name: In which month(s) of the previous three months do you have medical bills?
<b>SEND PROOF</b> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, who? Which state? Which county?
4. Does anyone who is applying have a pending lawsuit due to an injury?	<input type="checkbox"/> No <input type="checkbox"/> 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)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, who?

## SECTION H

### Parent or Spouse Not Living with 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.)	<input type="checkbox"/> No <input type="checkbox"/> 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)	<input type="checkbox"/> No <input type="checkbox"/> 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:
	Date of Birth (if known): / /	Street: _____ City/State: _____ SSN (if known): _____
Child's Name:	Name of parent living outside the home	Current or last known address:
	Date of Birth (if known): / /	Street: _____ City/State: _____ SSN (if known): _____

3. Is anyone applying still married to someone who lives outside the home?	<input type="checkbox"/> No <input type="checkbox"/> 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: _____ SSN (if known): _____
Date of Birth (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)
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

**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](http://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/](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:

X

Employed By: (check one)  Health Plan  Local Department of Social Services  Provider Agency  Qualified Entities

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

Denial Code  Withdrawal Code

Proxy:

No  Yes

Registry #:

Ver:





# Supplement A

(Supplement to Access NY Health Care Application DOH-4220)

## This Supplement must be completed if anyone who is applying is:

- Age 65 or older
- Certified blind or certified disabled (of any age)
- Not certified disabled but chronically ill
- Institutionalized and applying for coverage of nursing home care.  
This includes care in a hospital that is equivalent to nursing home care.

Note: If you are applying for the Medicare Savings Program (MSP) only, this Supplement does not need to be completed.

### INSTRUCTIONS:

- Sections A through E must be completed and this Supplement must be signed.
- If you or anyone in your household is applying for coverage of nursing home care, you must also complete sections F through G.

## A. Applicant and Spouse Information

### 1. Applicant(s) this Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Marital Status	Social Security Number	Date of Birth	If Deceased, List Date of Death
					/ /	/ /
					/ /	/ /

#### Is a person named above:

- Chronically ill?  Yes  No  
*(Examples of chronically ill would be unable to work for at least 12 months because of an illness or injury, or having an illness or disabling impairment that has lasted or is expected to last for 12 months.)*
- Certified Blind by the Commission for the Blind and Visually Handicapped?  Yes  No  
*(If yes, send proof.)*
- Interested in applying for the MBI-WPD program if disabled and working?  Yes  No  
*The Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program offers Medicaid coverage to people who are disabled, working, and at least 16 years old but not yet 65 years old. The program allows higher income levels than the regular Medicaid program so working people with disabilities can earn more and keep their Medicaid coverage.*

**If an applicant is living in a long-term care facility/nursing home, adult home, or assisted living facility, provide the following information.**

Name of Applicant who is in Facility	Name of Facility	Date Admitted / /	Telephone Number ( ) -
Street Address	City	State	Zip Code
Applicant's Previous Address	City	State	Zip Code

**If the above previous address was also a facility or adult home, list the address prior to admission below.**

Applicant's Second Previous Address	City	State	Zip Code
-------------------------------------	------	-------	----------

**2. Applicant's Spouse: (if not listed above)**

Legal Last Name	Legal First Name	MI
Maiden Name or Other Name Known By:	Social Security Number	Date of Birth / /
Street Address (if in a facility, list spouse's address prior to being admitted to facility)		
City	State	Zip Code

**Is the applicant's spouse living in a long-term care facility/nursing home?**

Yes  No

If yes, provide the following information:

Name of Facility	Date Admitted / /	Telephone Number ( ) -
Street Address	City	State
		Zip Code

**Is the applicant's spouse deceased?**  Yes  No      If yes, what is the date of death? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## B. What Care and Services are you Applying for? (check the box that applies)

- You are applying for Medicaid coverage but not coverage of community-based long-term care services.** You may attest to the amount of your resources. You are not required to submit documentation of your resources at this time. If a computer match shows something different than what you reported, you may be asked to submit proof at a later date.

This coverage does not include nursing home care, home care or any of the community-based long-term care services listed below.\*

- You are applying for coverage of community-based long-term care services.** Documentation of the **current** amount of your resources is required. However, you only need to submit documentation for certain resources at this time. See “Documentation Requirements” below for a list of these resources.

This coverage includes the following services:\*

- Adult day health care
- Limited licensed home care
- Private duty nursing
- Hospice in the community
- Hospice residence program
- Assisted living program
- Consumer directed personal assistance program
- Certified Home Health Agency services
- Residential treatment facility care
- Personal emergency response services
- Personal care services
- Managed long-term care in the community
- Waiver and other services provided through a home and community-based waiver program

**Note:** Some examples of home and community-based programs that provide waiver and other services are Traumatic Brain Injury Program and Nursing Home Transition and Diversion Program.

- You are institutionalized and applying for coverage of nursing home care.** Documentation of your resources for the **past 60 months** is required. However, you only need to submit documentation for certain resources at this time. See “Documentation Requirements” below for a list of these resources.

\*You may be eligible for short-term rehabilitation services. Short-term rehabilitation services include one commencement/admission in a 12-month period of up to 29 consecutive days of nursing home care and/or certified home health care.

## DOCUMENTATION REQUIREMENTS

If you are requesting coverage for **community-based long-term care services** or **nursing home care**, provide documentation for the time period indicated above for all of the following resources, if applicable.

- Life insurance policy;
- Securities, stocks, bonds, and mutual funds;
- Annuities;
- Burial agreement or fund;
- Trust document and accounts.

**You do not need to send proof of any other resources at this time.** This is because other resources may be verified through computer matches. If the resources you report do not match our records or cannot be verified through our records, we may ask you to submit proof of those other resources at a later date.

## C. Resources/Assets

### INSTRUCTIONS FOR SECTIONS 1 THROUGH 8:

- List all resources currently owned by you and/or your spouse/parent(s), including custodial accounts.
  - Check the “NONE” box if you and/or your spouse/parent(s) do not own any of those resources.
  - If applying for coverage of nursing home care, also list any accounts CLOSED in the past 60 months; include the balance at closing and provide an explanation of where the balance was transferred to or how it was spent. On a separate sheet of paper, provide an explanation of each transaction of \$2,000 or more.
- Note: Medicaid retains the right to review all transactions made during the transfer look-back period.

1. Checking/Savings/Credit Union Accounts/Certificates of Deposits (CDs):						<input type="checkbox"/> NONE
Bank Name	Account Number	Name of Owner(s)	Current Account Balance	Closed Accounts		Balance at Closing
				Date Closed		
			\$	/ /		\$
			\$	/ /		\$
			\$	/ /		\$
			\$	/ /		\$
			\$	/ /		\$
			\$	/ /		\$
			\$	/ /		\$
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			\$	/ /		\$
			\$	/ /		\$
			\$	/ /		\$
			\$	/ /		\$

  

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh):						<input type="checkbox"/> NONE	
Institution Name	Account Number	Name of Owner(s)	Pay Out	Current Account Balance	Closed Accounts		Balance at Closing
					Date Closed		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	/ /		\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	/ /		\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	/ /		\$
			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	/ /		\$

  

3. Annuities, Stocks, Bonds, Mutual Funds:						<input type="checkbox"/> NONE	
Institution/Company Name	Account Number	Name of Owner(s)	Date Purchased	Current Value	Closed Accounts		Value at Closing
					Date Closed or Sold		
				\$	/ /		\$
				\$	/ /		\$
				\$	/ /		\$
				\$	/ /		\$
				\$	/ /		\$
				\$	/ /		\$

**4. Life Insurance Policies:** **NONE**

Insurance Company	Policy Number	Name of Owner(s)	Current Cash Value	Current Face Value	Cancelled Policies	
					Date Cancelled	Cash Out Value
			\$	\$	/ /	\$
			\$	\$	/ /	\$
			\$	\$	/ /	\$
			\$	\$	/ /	\$
			\$	\$	/ /	\$

**5. Burial Assets/Burial Contracts: (Include copies):** **NONE**

- a. Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family?  Yes  No
- b. Do you and/or your spouse have a burial space or plot for you or anyone else in your family?  Yes  No
- c. Do you and/or your spouse have money in a bank account set aside for a burial fund?  Yes  No

If yes, in what account(s) is your and/or your spouse's burial fund?

Bank Name and Account Number	Name of Owner(s)	Value
		\$
		\$
		\$

- d. Do you have life insurance to be used as your burial fund?  Yes  No

If yes, what is your policy number(s)? \_\_\_\_\_

- 
- Yes
- 
- No

- e. Does your spouse have life insurance to be used as a burial fund?  Yes  No

If yes, what is the policy number(s)? \_\_\_\_\_

- 
- Yes
- 
- No

If yes, is the full cash value to be used for burial expenses? \_\_\_\_\_

If yes, is the full cash value to be used for burial expenses? \_\_\_\_\_

- 
- Yes
- 
- No

**6. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the current schedule of trust assets.** **NONE**

Name of Trust	Grantor	Trustee(s)	Assets	Beneficiary	Income
			\$		\$
			\$		\$
			\$		\$
			\$		\$

**7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles.** **NONE**

Name of Owner(s)	Year/Make/Model	Fair Market Value	Amount Owed	In use?	Date Sold
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /

**8. List Any Other Resources:**

Resource Type	Name of Owner(s)	Value
		\$
		\$
		\$
		\$
		\$
		\$

**D. Homestead**1. Do you and/or your spouse own or have a legal interest in your home, including a life estate?  Yes  No2. If you are in a medical facility and own your home, do you intend to return to your home?  Yes  NoIf no, is anyone living in the home?  Yes  No

Who is living in the home? \_\_\_\_\_

How is this person related to you and/or your spouse? \_\_\_\_\_

If you and/or your spouse's child (of any age) is living in the home, is the child disabled?  Yes  No**Note:** If there is a legal impediment that prevents you from selling this property, the property is not counted in determining Medicaid eligibility. Send proof of legal impediment.

3. Equity Value in Home:

If you own your home, what is the equity value in your home? \$ \_\_\_\_\_

**Note:** Equity value is the fair market value less any outstanding liens, mortgages, etc.**E. Real Property (other than your home)**Do you and/or your spouse own or have a legal interest in any other real property? (Check any that apply)  Yes  No

Rental Property     Vacation Property     Time Share     Vacant Land     Other Property Rights  
 (In or outside of New York State)

If yes, provide the following information:

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$

**STOP HERE unless you or anyone in your household is institutionalized and applying for coverage of nursing home care. However, Section I of this document MUST be signed.**

## F. Asset Transfers

### 1. Transfers

a. In the last 60 months, did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real property?  Yes  No

b. In the last 60 months, have you or your spouse created or transferred any assets into or out of a trust?  Yes  No

If you answered yes to either of the questions above, explain the transfer(s) below.

Attach additional sheets of paper, if needed.

Description of Asset (including income)	Date of Transfer	Transferred to Whom	Amount of Transfer
			\$
			\$
			\$
			\$

c. Are you in the process of selling property?  Yes  No

d. In the last 60 months, did you, your spouse or someone on your behalf, change the deed or the ownership of any real property, including creating a life estate?  Yes  No

If yes, when? \_\_\_\_\_

e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate?  Yes  No

f. In the last 60 months, did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note?  Yes  No

If yes, when? \_\_\_\_\_

g. In the last 60 months, did you, your spouse, or someone on your behalf purchase or change an annuity?  Yes  No

If yes, when? \_\_\_\_\_

2. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, such as a nursing home, assisted living facility, continuing care retirement community or life care community?  Yes  No

If yes, send copy of agreement.

## G. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years?  Yes  No

If yes, send complete copies of these returns including all schedules and attachments.

## H. Important Information

### ■ Liens on Real Property

Upon receipt of Medicaid, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. Medicaid paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained. Medicaid may also recover the cost of services and premiums incorrectly paid.

### ■ Transfer of Assets

Federal and State laws provide that an individual may be found ineligible for nursing facility services for a period of time if an individual or an individual's spouse transfers an asset for less than fair market value within the look-back period. The look-back period is the 60 months immediately prior to the date an individual is both institutionalized and has applied for Medicaid.

### ■ Annuities

As a condition of Medicaid coverage for nursing facility services, applicants are required to disclose a description of any interest the individual or the individual's spouse has in an annuity. This disclosure is required regardless of whether the annuity is irrevocable or a countable resource.

In addition to the purchase of an annuity, certain transactions made to an annuity by the applicant or the applicant's spouse within the look-back period, may be treated as a transfer unless:

- The State is named the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant; or
- The State is named in the second position after a community spouse or minor or disabled child, or in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

If documentation is not submitted verifying that the State has been named remainder beneficiary, you may be ineligible for coverage of nursing facility services.

If the annuity is a countable resource at the time of application, you/your spouse are not required to name the State as remainder beneficiary.

## I. Certification and Authorization

I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

If eligibility depends on the amount of my and my spouse's resources, by signing this application we authorize verification of our resources with financial institutions for the purpose of determining eligibility. Both spouses must sign below. This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I/we revoke this authorization in a written statement to my local Department of Social Services.

X \_\_\_\_\_  
SIGNATURE OF APPLICANT/REPRESENTATIVE

X \_\_\_\_\_  
DATE SIGNED

X \_\_\_\_\_  
SIGNATURE OF APPLICANT'S SPOUSE

X \_\_\_\_\_  
DATE SIGNED

## **Passport**

---

[ passport ]

[ birth certificate, social security card, driver license ]

[insurance cards, scanned]

## **Medicare insurance coverage report**

---

[printout from Medicare 1]

[printout from Medicare 2]

[Medicare Premiums document]

[Nursing home admission record]

RUG II Group (print name)
RHCF Level of Care: <input type="checkbox"/> HRF <input type="checkbox"/> SNF

## Use with separate Hospital and Community PRI Instructions

### I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER  
(1-8)

2. SOCIAL SECURITY NUMBER  
(9-17) - - -

3. OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW

4A. PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY)

11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT

(49-56) - -  
MO DAY YEAR

4B. COUNTY OF RESIDENCE

11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE)

5. DATE OF PRI COMPLETION

(57-64) - -  
MO DAY YEAR

(18-25) - -  
MO DAY YEAR

12. MEDICAID NUMBER  
(65-75)

6. MEDICAL RECORD NUMBER/CASE NUMBER  
(26-34)

13. MEDICARE NUMBER  
(76-85)

7. HOSPITAL ROOM NUMBER  
(35-39)

14. PRIMARY PAYOR  
(86)

- 1=Medicaid  
2=Medicare  
3= Other

8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING

15. REASON FOR PRI COMPLETION  
(87)

1. RHCF Application from Hospital  
2. RHCF Application from Community  
3. Other (Specify: )

9. DATE OF BIRTH  
(40-47) - -  
MO DAY YEAR

10. SEX (48)  
1=Male  
2=Female

### II. MEDICAL EVENTS

16. DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS.

18. MEDICAL TREATMENTS: READ THE INSTRUCTIONS FOR THE QUALIFIERS.

- 1=YES  
2=NO

17. MEDICAL CONDITIONS: DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS

A. Trachesotomy Care/Suctioning (Daily—Exclude self-care)

1=YES

2=NO

- A. Comatose  
B. Dehydration  
C. Internal Bleeding  
D. Stasis Ulcer  
E. Terminally Ill  
F. Contractures  
G. Diabetes Mellitus  
H. Urinary Tract Infection  
I. HIV Infection Symptomatic  
J. Accident  
K. Ventilator Dependent

- B. Suctioning-General (Daily)  
C. Oxygen (Daily)  
D. Respiratory Care (Daily)  
E. Nasal Gastric Feeding  
F. Parenteral Feeding  
G. Wound Care  
H. Chemotherapy  
I. Transfusion  
J. Dialysis  
K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS)  
L. Catheter (Indwelling or External)  
M. Physical Restraints (Daytime Only)

### III. ACTIVITIES OF DAILY LIVING (ADLs)

Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.

#### 19. EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE) 19. (113)

1=Feeds self without supervision or physical assistance. May use adaptive equipment.  
2=Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.

3= Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.

4=Totally fed by hand, patient does not manually participate

5=Tube or parenteral feeding for primary intake of food. (*Not* just for supplemental nourishments)

#### 20. MOBILITY: HOW THE PATIENT MOVES ABOUT 20. (114)

1=Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.  
2=Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).

3= Walks with *constant* one-to-one supervision and/or constant physical assistance.

4= Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.

5= Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

#### 21. TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET). 21. (115)

1=Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.  
2=Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.

3=Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.

4=Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.

5=Cannot and is not gotten out of bed.

#### 22. TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN). TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES. 22. (116)

1=Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.  
2=Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands).

3=Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).

4=Incontinent of bowel *and/or* bladder and is not taken to a bathroom.

5=Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

### IV. BEHAVIORS

#### 23. VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC. 23. (117)

1=No known history  
2=Known history or occurrences, but not during the past week (7 days)  
3=Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)

4=Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason

5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions)

#### 24. PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY. (FOR EXAMPLE, HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR) 24. (118)

1=No known history.  
2=Known history or occurrences, but not during the past week (7 days).  
3=Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.

4=Unpredictable, recurring aggression at least once during the past week (7 days) for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).

5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

<b>25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR:</b> CHILDISH, REPETITIVE OR ANTI SOCIAL PHYSICAL BEHAVIOR WHICH CREATES <i>DISRUPTION WITH OTHERS</i> . (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS.	<b>25.</b> (119)
1=No known history	4=Occurrences of this disruptive behavior at least once during the past week
2=Displays this behavior, but is not disruptive to others (for example, rocking in place).	(7 days)
3=Known history or occurrences, but not during the past week (7 days).	5=Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).
<b>26. HALLUCINATIONS:</b> EXPERIENCED AT LEAST ONCE DURING THE PAST WEEK. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY.	<b>26.</b> (120)
1=Yes	2=No
	3=Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions)

## V. SPECIALIZED SERVICES

**27. PHYSICAL AND OCCUPATIONAL THERAPIES:** READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS).

A. Physical Therapy (P.T.)

P.T. Level  
(121)

P.T. Days  
(122)

P.T. Time  
(123-126) HOURS MIN/WEEK  
O.T. Level  
(127)

O.T. Days  
(128)

O.T. Time  
(129-132) HOURS MIN/WEEK

### LEVEL

1=Does not receive.

2= Maintenance program-Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.

3=Restorative Therapy-Requires and is currently receiving physical and/or occupational therapy for the past week.

4=Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, therapy provided for only two days).

**DAYS AND TIME PER WEEK:** ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS) THAT EACH THERAPY WAS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

**28. NUMBER OF PHYSICIAN VISITS:** DO NOT ANSWER THIS QUESTION FOR HOSPITALIZED PATIENTS, (ENTER ZERO), UNLESS ON ALTERENATE LEVEL OF CARE STATUS. ENTER ONLY THE NUMBER OF VISITS DURING THE PAST WEEK THAT ADHERED TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. THE PATIENT MUST BE MEDICALLY UNSTABLE TO ENTER ANY PHYSICIAN VISITS, OTHERWISE ENTER A ZERO.

**28.**

(133-134)

## VI. DIAGNOSIS

**29. PRIMARY PROBLEM:** THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME IN THE HOSPITAL OR CARE TIME IF IN THE COMMUNITY. (FOR HOSPITALIZED PATIENTS THIS MAY OR MAY NOT BE THE ADMISSION DIAGNOSIS).

ICD-9 Code of medical problem

**29.** -  
(135-139)

If code cannot be located, print medical name here:

## VII. PLAN OF CARE SUMMARY

This section is to communicate to providers any additional clinical information, which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is attached to this H/C-PRI.

### 30. DIAGNOSES AND PROGNOSIS: FOR EACH DIAGNOSIS, DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS.

Primary Prognosis

1.

Secondary (Include Sensory Impairments)

1.

2.

3.

4.

### 31. REHABILITATION POTENTIAL (INFORMATION FROM THERAPISTS)

A. POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC-PRI):

B. CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

### 32. MEDICATIONS

NAME	DOSE	FREQUENCY	ROUTE	DIAGNOSIS REQUIRING EACH MEDICATION
------	------	-----------	-------	-------------------------------------

### 33. TREATMENTS: INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

A. TREATMENTS	DESCRIBE WHY NEEDED	FREQUENCY
---------------	---------------------	-----------

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

### 34. RACE/ETHNIC GROUP: ENTER THE CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP

1=White                  4=Black/Hispanic                  7=American Indian or Alaskan Native

2=White/Hispanic    5=Asian or Pacific Islander    8=American Indian or Alaskan Native/Hispanic

3=Black                  6=Asian or Pacific Islander/Hispanic    9=Other

### 35. QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C PRI.

YES     NO

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

IDENTIFICATION NO.

SIGNATURE OF QUALIFIED ASSESSOR

**RESIDENTIAL HEALTH CARE FACILITY REPORT OF  
MEDICAID RECIPIENT ADMISSION/DISCHARGE/READMISSION/CHANGE IN STATUS**

TO: (PATIENT'S/RESIDENT'S LOCAL DEPARTMENT OF SOCIAL SERVICES OFFICE)		FROM: (REPORTING FACILITY)	
PATIENT/RESIDENT NAME ( <i>Last, First, M.I.</i> )	PROVIDER NUMBER	TYPE OF PLACEMENT <input type="checkbox"/> SNF <input type="checkbox"/> ICF	
MEDICAID CLIENT IDENTIFICATION NUMBER	DATE OF ADMISSION/READMISSION:		
SOCIAL SECURITY NUMBER	DATE OF DISCHARGE/TRANSFER:		
FROM: (FACILITY OR HOME ADDRESS)	TO: (FACILITY OR HOME ADDRESS; or INDICATE IF DECEASED)		
Bed was reserved <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	Bed was reserved <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		
PATIENT IS ENROLLED IN MEDICAID MANAGED CARE:  <input type="checkbox"/> Yes <input type="checkbox"/> No	MEDICAID MANAGED CARE PLAN WAS NOTIFIED OF ADMISSION, DISCHARGE, OR CHANGE IN STATUS:  <input type="checkbox"/> Yes <input type="checkbox"/> No		
NAME OF MEDICAID MANAGED CARE PLAN:	DATE NOTIFIED:		

**LDSS-3559 is required from the facility for each individual upon initial admission, and for every change in placement status, including upgrade to permanent placement, readmission, transfer, discharge or death of the patient after admission. Prompt submission of this completed form to the Local Department of Social Services (LDSS) responsible for the client will ensure timely payment by Computer Sciences Corporation/Medicaid Managed Care plan to the billing provider.**

**Indicate placement situation for this patient:**

- Placement is for short term rehabilitation, which is expected to be less than 29 consecutive days (for Medicaid eligibility determination purposes only).
- Placement is considered to be permanent. The individual is not expected to return home to a community setting.
- Placement is considered to be non-permanent. The individual is expected to return home to a community setting.

**NOTE: A physician must complete and sign the attached statement indicating the diagnosis, prognosis, expected time frame and the anticipated discharge plan for a non-permanent admission.**

**NOTE: The facility is responsible for obtaining prior approval and billing Medicaid Managed Care plans for medically necessary non-permanent stays. If the placement is determined to be permanent, the facility must include a medical determination to facilitate disenrollment from the Medicaid Managed Care plan.**

**Health Insurance Information:**

- The individual is in receipt of Medicare coverage for nursing facility services and/or has other health insurance coverage at the time of admission.
- Medicare or other third party health insurance coverage was terminated on \_\_\_\_\_ (date).

NAME OF INDIVIDUAL COMPLETING THIS FORM <i>(Please print)</i>	TITLE	TELEPHONE NO. ( )
--	-------	----------------------

**FACILITY MUST SUBMIT COMPLETED FORM WITHIN 48 HOURS OF ADMISSION/DISCHARGE OR ANY CHANGE IN PATIENT STATUS**

<b>Physicians Statement of Temporary Nursing Home Placement</b>			
<b>STATEMENT OF PURPOSE</b>			
<p>The information provided will help determine the appropriate budgeting methodology to use for Medicaid eligibility purposes for the Medicaid applicant/recipient and to ensure appropriate Medicaid payments to the nursing facility. Establishing the intent and purpose of admission to the nursing facility will also aid in the determination of payment liability from Medicaid or the recipient's Medicaid Managed Care plan.</p>			
PATIENT NAME	Date of Birth	Social Security Number	SEX
HOME ADDRESS: APT/STREET	City	State	Zip Code
Facility Name/ Address	Anticipated timeframe for discharge		
Reason for nursing home admission including diagnosis, prognosis, discharge plan and reason for non-permanent placement.			
<b>Physician's Certification</b>			
<p>I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and that I may be contacted, if necessary, for further clarification.</p>			
(Print) Physician's Name	Physician's Signature		
Date	Contact Phone Number		
<b>Information for LDSS</b>			
<p>When the physician statement verifies that the above individual's placement in a residential health care facility is non-permanent and the recipient is enrolled in Medicaid Managed Care, s/he is not disenrolled from the plan. The facility is responsible for billing the Medicaid Managed Care plan for medically necessary non-permanent (rehabilitation) stays. If a RHCF stay is subsequently classified as a permanent placement, the individual should be disenrolled from the Medicaid Managed Care plan effective the first day of the month in which the stay is classified as permanent. This will allow the facility to bill fee-for-service from the date the member was determined permanent.</p>			

# PART 2

## Income Verification

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SSA-1099SM: SSDI Benefit Statement for [lastyear] . . . . .	61
Bankname3 retirement account payout confirmation . . . . .	63

## SUMMARY OF MONTHLY INCOME (2026)

Source	Document	Gross Amt	Notes
<b>Social Security</b>	nextyear COLA Notice	\$xxxx.xx	<b>Gross Benefit.</b> Includes nextyear COLA. (Net deposit will be \$xxxx.xx after \$202.90 Medicare premium deduction).
<b>Bankname3 Annuity</b>	Payout Confirmation	\$xxx.xx	<b>New Income Stream.</b> Systematic withdrawal elected [Month year].
<b>TOTAL</b>		\$xxxx.xx	<b>Total Anticipated Gross Monthly Income</b>

### Supporting Documentation

- **2026 Social Security COLA Notice:** Confirms the new [year] benefit amount. (p. 58)
- **SSA Benefit Verification Letter:** Confirms current active status. (p. 59)
- **SSA Payment History:** Detailed ledger of disbursements. (p. 61)
- **SSA-1099 (year):** Historical income reference. (p. 61)
- **Bankname3 systematic monthly payout confirmation:** Documentation of Payout Mode election (Month year). (p. 63)

[Social Security COLA document]



## Social Security Administration Benefit Verification Letter

Date: [REDACTED] 2025

BNC#:

REF: [REDACTED] DI



You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

### Information About Current Social Security Benefits

Beginning December 2024, the full monthly Social Security benefit before any deductions is \$[REDACTED].

We deduct \$[REDACTED] for medical insurance premiums each month.

The regular monthly Social Security payment is \$[REDACTED].  
(We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the third of each month.

We found that you became disabled under our rules on [REDACTED].

### Information About Past Social Security Benefits

From January 2024 to November 2024, the full monthly Social Security benefit before any deductions was \$[REDACTED].

We deducted \$[REDACTED] for medical insurance premiums each month.

The regular monthly Social Security payment was \$[REDACTED].  
(We must round down to the whole dollar.)

### Type of Social Security Benefit Information

You are entitled to monthly disability benefits.

See Next Page

### **Information About Current Social Security Benefits**

Beginning [REDACTED], the full monthly Social Security benefit before any deductions is \$0.00.

We deduct \$0.00 for medical insurance premiums each month.

The regular monthly Social Security payment is \$0.00.  
(We must round down to the whole dollar.)

Benefits were stopped beginning [REDACTED]

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the third of each month.

### **Type of Social Security Benefit Information**

You are entitled to monthly benefits as a dependent of the wage earner.

### **Medicare Information**

You are entitled to hospital insurance under Medicare beginning [REDACTED]

You are entitled to medical insurance under Medicare beginning [REDACTED]

Your Medicare number is [REDACTED]. You may use this number to get medical services while waiting for your Medicare card.

If you have any questions, please log into Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

### **Date of Birth Information**

The date of birth shown on our records is [REDACTED]

### **Suspect Social Security Fraud?**

Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

### **If You Have Questions**

#### **Need more help?**

1. Visit [www.ssa.gov](http://www.ssa.gov) for fast, simple and secure online service.
2. Call us at 1-800-772-1213, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY 1-800-325-0778. Please mention this letter when you call.
3. You may also call your local office at 1-877-714-0372.

SOCIAL SECURITY  
650 GRAVOIS BLUFF BLVD  
FENTON MO 63026

[printout of recent payments from social security to the applicant]

**FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT****2019**

- PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.
- SEE THE REVERSE FOR MORE INFORMATION.

Box 1. Name

Box 2. Beneficiary's Social Security Number

Box 3. Benefits Paid in 2019

Box 4. Benefits Repaid to SSA in 2018

Box 5. Net Benefits for 2018 (Box 3 minus Box 4)

**DESCRIPTION OF AMOUNT IN BOX 3****DESCRIPTION OF AMOUNT IN BOX 4**

Box 6. Voluntary Federal Income Tax Withholding

Box 7. Address

Box 8. Claim Number (*Use this number if you need to contact SSA.*)

Form SSA-1099-SM (6-2019)

**DO NOT RETURN THIS FORM TO SSA OR IRS**

[documentation of new Bankname3 payout]

# PART 3

## Resources & Asset History

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C. Bankname3 Retirement (Asset History) . . . . .	73
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## Resource Summary

### Asset Snapshot as of application date

The following table summarizes all liquid assets owned by the applicant.

**Total Countable Resources are BELOW the Medicaid Resource Limit.**

Asset	Current Value	Medicaid Status
1. Bankname Checking (account ending in xxxx)	\$xxxxx.xx	Countable Resource
2. Bankname Checking (account ending in xxxx)	\$xxx.xx	Countable Resource
3. Bankname Retirement account number	(See Note)	EXEMPT (Converted to Income Stream)
<b>TOTAL RESOURCES</b>	<b>\$xxxxx.xx</b>	<b>ELIGIBLE</b> (Below Resource Limit)

#### **! IMPORTANT NOTE REGARDING RETIREMENT ACCOUNT**

The retirement account (balance of approx. \$XXXXXXX) has been placed into **Systematic Withdrawal (Payout) Mode**.

- Per NYS Medicaid regulations, this asset has been converted to a **stream of monthly income**.
- Please refer to **Part 2 (Income)** for the verification of the monthly payments.
- **Do NOT count the balance as a resource.**

*Detailed 5-year statements and transaction audits  
for the accounts listed above follow in this section.*

## A. Bankname Checking Audit

### Explanation of Large Transactions (>\$2,000)

**Account Owner:** Firstname Lastname

**Account Number:** Ending in xxxx

**Audit Period:** [last five years]

#### Account Narrative

This account serves as the primary funding source for the applicant's living expenses.

- **Routine Income:** Monthly Social Security (SSDI) deposits of approx. \$xxxx. (Bankname3 payouts of net \$xxx/month are starting.)
- **Routine Expenses:** Rent, utilities, food, etc.
- **Opening Balance Note:** The opening deposit of \$xxxxx.00 (month year) represents the applicant's accumulated life savings, deposited as cash. (See bank record, p. 100).

#### Large Transaction Audit (>\$2,000)

Date	Type	Amount	Explanation / Source
year-MM-DD	Withdrawal	-\$xxxxxx.xx	<b>Medicaid Trust Funding.</b> Transfers to NYSARC (d4C) and Funeral Trust. (See Part 4.)
year-MM-DD	Check #xxx	-\$xxxx.00	<b>NYS Tax (Reimbursement).</b> Repayment to daughtername Lastname for tax bill. (See p. 67).
year-MM-DD	E-Check #xxx	-\$xxxx.00	<b>Tax Payment.</b> US Treasury (IRS) payment for [year] Tax Year. (See p. 103).
year-MM-DD	Deposit	\$xxxxxx.xx	<b>Inheritance.</b> Bankname3 Life Insurance payout (Est. momfirstname Lastname). (See p. 99).
year-MM-DD	Deposit	\$xxxx.00	<b>SSA TREAS 310.</b> Social Security retroactive/lump sum payment.
year-MM-DD	Check #xxx	-\$xxxx.00	<b>Transfer to Self.</b> Funds moved to open Bankname2 FCU account. (See Bankname2 FCU audit, p. 72).
year-MM-DD	Deposit	\$xxxxx.00	<b>Opening Deposit.</b> Cash deposit. (See bank record, p. 100).

## NYS Tax Reimbursement

**Transaction Summary:** Month day year: Applicant reimbursed daughter \$xxxx via Check #xxx for a tax bill daughter paid on her behalf.

---

### 1. THE REIMBURSEMENT (Dec year)

[check image]

### 2. ORIGINAL PAYMENT RECEIPT (Apr year)

Official Receipt showing Daughtername Lastname paid \$xxxx to NYS Dept of Taxation using her personal checking account. (next page)



# Application for Automatic Extension of Time to File for Individuals (with instructions)

**IT-370**

Print or type	Your first name and middle initial	Your last name (for a joint return, enter spouse's name on line below)	▼ Your social security number		
	Spouse's first name and middle initial	Spouse's last name	▼ Spouse's social security number		
	Mailing address (number and street or rural route)		Apartment number		
	City, village or post office	State	ZIP code		

**This is not an extension of time for payment of tax** (see Penalties and Interest in the instructions).

In order to get this extension you **must** pay in full the balance due with this form. Attach check or money order payable to **New York State Income Tax**, write your social security number and **2003 Income Tax** on your remittance and staple it to the top of this form.

- 1 New York State tax liability for 2003 .....
- 2 City of New York tax liability for 2003 .....
- 3 City of Yonkers tax liability for 2003 .....
- 4 Sales or use tax (see instructions) .....
- 5 Total taxes (add lines 1 through 4) .....
- 6 Total payments for 2003. This is the amount you expect  to enter on Form IT-201, line 69, or Form IT-203, line 61 (excluding amount paid with Form IT-370) .....
- 7 Balance due (subtract line 6 from line 5; if line 6 is more than line 5, enter "0") .....

Dollars	Cents
1.	•
2.	•
3.	•
4.	•
5.	•
6.	•
7.	•

## Instructions (do not detach)

**Purpose** — File Form IT-370 on or before the due date of the return to get an automatic four-month extension of time to file Form IT-201, *Resident Income Tax Return*, or Form IT-203, *Nonresident and Part-Year Resident Income Tax Return* (including attachments).

If you are requesting an extension of time to file using Form IT-370 or a copy of federal Form 4868, you may still file Form IT-201 electronically, provided you meet the conditions for electronic filing as listed in the instructions for Form IT-201.

If you are married and filing separately, you must file a separate application for automatic extension for each return.

If you have to file Form Y-203, *City of Yonkers Nonresident Earnings Tax Return*, the time to file is automatically extended when you file Form IT-370. For more information on who is required to file Form Y-203, see the instructions for the form.

**Forms IT-100 and IT-200** — You cannot extend the time to file Form IT-100 or Form IT-200. If you want to file one of these returns, you must file on time. If you cannot file on time, you must use Form IT-201 when you file.

**U.S. citizens abroad** — If you qualify for a two-month automatic extension of time to file your federal income tax return because (1) you are a U.S. citizen or resident and live outside the U.S. and your main place of business or post of duty is outside the U.S. and Puerto Rico or (2) you are in military service outside the U.S. and Puerto Rico when your 2003 return is due, you are entitled to a similar two-month automatic extension to file your New York income tax return and to pay your tax. You must attach to your New York State return a statement showing that you qualify for the federal automatic two-month extension. If you cannot file on or before the end of this automatic two-month extension, file Form IT-370 and pay any tax due with it to receive an additional two months to file. If you still need more time, you must file Form IT-372 (see *Filing Form IT-372* in these instructions).

**When to file** — File **one** completed Form IT-370 on or before the filing deadline for your return. For calendar year 2003, the filing deadline is April 15, 2004. For fiscal-year filers, the filing deadline is the fifteenth day of the fourth month following the close of your tax year. Extension applications filed after the filing deadline of the return will be rejected.

**How to file** — Complete Form IT-370 for the return that you are extending the time to file. File it, along with payment for any tax due, on or before the due date of your return.

Separate Forms IT-370 must be completed for a husband and wife who file separate returns.

You may also file an extension request online by visiting our Web site at [www.nystax.gov](http://www.nystax.gov) and clicking on *Electronic Services*.

Partnerships and fiduciaries must use Form IT-370-PF, *Application for Automatic Extension of Time to File for Partnerships and Fiduciaries*, also available online.

**Acceptance of federal Form 4868, Application for Automatic Extension of Time To File U.S. Individual Income Tax Return** — If you expect to receive a refund or anticipate having no amount of New York State, New York City or Yonkers income tax or state or local sales or use tax remaining unpaid as of the due date of the return, we will accept a copy of federal Form 4868. Send us a copy of federal Form 4868 on or before the due date of your return. Write **New York State Copy** at the top of the form.

**Payment of tax** — In order to obtain an extension of time to file, full payment must be made of the properly estimated tax balance due. Payment may be made by check or money order enclosed with Form IT-370 or by credit card (see instructions for line 7 on the back).

**Penalties — Late payment penalty** — If you do not pay your income tax liability when due (determined with regard to any extension of time to pay), you will have to pay a penalty of  $\frac{1}{2}$  of 1% of the unpaid amount for each month or part of a month it is not paid, up to a maximum of 25%. The penalty will not be charged if you can show reasonable cause for paying late. This penalty is in addition to the interest charged for late payments.

Reasonable cause will be presumed with respect to the addition to tax for late payment of income tax if the requirements relating to extensions of time to file have been complied with, the balance due shown on the income tax return, reduced by any sales or use tax that is owed, is no greater than 10% of the total New York State, New York City, and Yonkers income tax shown on the income tax return, and the balance due shown on the income tax return is paid with the return.

[receipt with proof daughter paid state taxes]

### **3. THE LIABILITY ([year] Tax Year)**

*Excerpts from [year] NYS Tax Return showing amount owed matches \$xxxx.*

[excerpts from NYS tax return] (...*Skipping to Line 61...*) At the time of filing the state taxes,

Daughtername had already paid New York State.

*(Full Tax Return attached in Part 5 C, p. 104).*

**Conclusion:** This was a dollar-for-dollar reimbursement for a valid expense, not a gift.

[huge packet of bank statements]

## B. Bankname2 FCU Audit

**Account Owner:** Firstname Lastname  
**Financial Institution:** Bankname2 Federal Credit Union  
**Primary Account:** Checking (Share Draft) – Active (Routine expenses)  
**Secondary Account:** Savings (Share) – Inactive / Nominal Balance (~\$1.00)

### Account Narrative

---

The Checking account was opened in Month year for routine expenses for the applicant. It was funded by a transfer from the applicant's primary Bankname account.

Activity consists primarily of the initial funding and subsequent routine withdrawals for living expenses (rent checks, utilities, and pharmacy co-pays). There was a recent deposit from Bankname of \$xxx.00 on Month date, year.

*Note: The attached statements also reflect a mandatory Share Savings account which has maintained a nominal balance (approx. \$1.00) since opening. This savings account is inactive.*

### Funding Source (Chain of Custody)

---

Date	Type	Amount	Explanation
year-MM-DD	Deposit	\$xxxx.00	<b>Opening Transfer.</b> Funds from Bankname Check #xxx. (See Bankname audit, p. 66).

[printout of Bank2 checking and savings balances from website]

[printout of Bank2 checking recent transactions from website]

[bank statements, five years]

# **Bankname3 Retirement Audit**

#### 5-Year Medicaid Lookback (Month year – Month year)

**Account Owner:** Firstname Lastname

**Account Numbers:** xxxxxxxxxxxxxxxx

**Status:** **Payout Mode (Systematic Withdrawals Active)**

## Account Narrative

This is a pre-tax retirement annuity. The account has entered "Payout Mode" as of late [year] to generate monthly income for the applicant.

**Compliance Note:** The table below confirms that no lump-sum withdrawals or transfers to third parties occurred during the lookback period. All activity was passive market fluctuation until the recent establishment of systematic payouts (net \$xxx/month).

## **Withdrawal Audit (Lookback Period)**

[webpage printout showing current balance and recent transactions for Bankname3]

[huge packet of statements from last 5 years]

# PART 4

## The Spend-Down (Irrevocable Trusts)

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# EXEMPT ASSETS & TRUST FUNDING

## Final Spend-Down to Eligibility Limits

### Summary of Compliance:

- Both asset transfers are **exempt** under NYS Medicaid rules.
- **Funding Source:** Bankname Official Checks (withdrawn Month day, year).

Trust Entity	Trust Type	Amount	Funding Instrument
NYSARC, Inc. Community Trust	Pooled Trust	\$xxxxxx.xx	Bankname Official Check #xxxxxxxxxx
Funeral Home	Irrevocable Funeral Trust	\$xxxxxx.00	Bankname Official Check #xxxxxxxxxx

### Attached Documentation:

1. **Exhibit A (NYSARC):** Copy of Funding Check stub and Joinder Agreement.
2. **Exhibit B (Funeral):** Copy of Funding Check stub, Itemization, and Trust Contract.

## **A. NYSARC Pooled Trust (d4C)**

### **Transfer to NYSARC Pooled Trust (d4C)**

---

Exempt Asset Transfer.

[scan of official check sent to fund NYSARC]



## NYSARC, INC. COMMUNITY TRUST

# JOINDER AGREEMENT

(COMMUNITY TRUSTS I & II)

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Revised June 2021

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P: (518) 439-8323  
F: (518) 439-2670

PO Box 1531  
Latham, NY 12110

# **NYSARC, Inc. Community Trust Joinder Agreement**

**This is a legal document. It is an agreement pertaining to a supplemental needs trust created pursuant to 42 United States Code §1396. You are encouraged to seek independent, professional advice before signing this agreement.**

The undersigned hereby adopts, enrolls in and establishes a sub-trust account under the **NYSARC, INC. COMMUNITY TRUST I (“CT I”)** dated April 19, 1997 and as amended **OR** under the **NYSARC, INC. COMMUNITY TRUST II (“CT II”)** dated October 17, 2002 and as amended, both trusts incorporated herein by reference. The undersigned also consents to NYSARC, Inc.’s determination as to which Trust (CT I or CT II) the beneficiary may be assigned. **These Trusts are Irrevocable.**

***NOTE: All questions must be answered or your application will be delayed.***

**1. Disabled Beneficiary/Donor:** \_\_\_\_\_

(First Name, Middle Name, Last Name)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_(mm/dd/yyyy)

Address: \_\_\_\_\_

Telephone Number of Donor: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_(Home) (\_\_\_\_) \_\_\_\_-\_\_\_\_\_(Mobile)

Email Address: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse’s name if married: \_\_\_\_\_

(First Name/Last Name)

**2. Beneficiary’s Qualifying Disability(ies):** \_\_\_\_\_

**3. Court Order:**

Is the Trust being established as the result of a Court Order? Yes  No

*If yes, please include a copy of the Court Order.*

**4. Funding: (indicate all that are applicable):**

Surplus monthly income/NAMI deposits

Indicate monthly deposit amount: \_\_\_\_\_

Lump Sum

Structured settlement payment (Please provide settlement order.)

Other (e.g. occasional resource deposits)

Describe: \_\_\_\_\_

*Note: This is supplemental information for NYSARC, Inc. purposes only. This amount may be changed at any time with no effect on the Joinder Agreement.*

**5. Beneficiary's Income:**

Indicate what sources of income the Beneficiary receives:

Social Security (Indicate Benefit Type)\*:

Social Security Retirement Income (SSA)? Yes  No

Social Security Disability Income (SSDI)? Yes  No

Supplemental Security Income (SSI)? Yes  No

Social Security Survivor/Dependent Benefits? Yes  No

**\*Provide copy of Social Security Award letter, indicating your claim number.**

Other income? Yes  No

*If yes, please provide source, amount and frequency.*

---

**6. Benefits:**

Does the Beneficiary receive Medicaid? Yes  No  Pending

If yes, list Medicaid Case #: \_\_\_\_\_

Please list other monthly benefits that the Beneficiary receives, such as Food Stamps,  
HUD Section 8, etc.: \_\_\_\_\_  

---

**7. Living Arrangements: (indicate the living arrangement of the Beneficiary):**

Independently	<input type="checkbox"/>	CR/IRA/ICF (supervised)	<input type="checkbox"/>
With Spouse	<input type="checkbox"/>	CR/IRA (supportive)	<input type="checkbox"/>
With Family/Parents	<input type="checkbox"/>	Family Care Program	<input type="checkbox"/>
Assisted Living Facility	<input type="checkbox"/>	Nursing Home	<input type="checkbox"/>

Other (explain) \_\_\_\_\_

If in an OPWDD residential program, does the Beneficiary receive community funds (e.g. clothing allowance)?

Yes  No  If yes, how much and how often received? \_\_\_\_\_

**8. Beneficiary Services:**

List other services that the Beneficiary receives (include day services, service coordination, employment programs, etc.):

<u>Service</u>	<u>Name of Provider</u>
_____	_____
_____	_____

**If the Beneficiary has a Representative Payee,** please list their name and contact information. *Note: By listing a rep payee, you authorize NYSARC to communicate with this person regarding your trust account.*

\_\_\_\_\_  
\_\_\_\_\_

**9. Guardianship:**

Is there a court appointed Guardian for the Beneficiary? Yes  No

**If yes, attach copy of Decree and Letters of Guardianship (Art. 17A) OR Guardianship Order and Commission (Art. 81) and complete the following:**

Guardian of the:      Person      Property      Both

Please list name(s) and address(es) of Guardian(s):

Are Standby and/or Alternate Standby Guardian(s) appointed? Yes  No

If yes, for the:      Person      Property      Both

Please list name(s) and address(es) of Standby and/or Alternate Standby Guardian(s):

---

**10. Authorized Contacts:**

***Note: All authorized contacts listed can communicate with NYSARC and obtain information about your trust account from customer service, the automated phone system, and the Online Portal, including but not limited to, account activity, trust forms, and legal documents for reporting purposes. Only contacts who are specifically authorized below can submit disbursement requests on the Beneficiary's behalf.***

***You must list at least one authorized contact who can submit requests.***

Name: \_\_\_\_\_  Receive Monthly Statements  Submit Requests for Disbursements

Address: \_\_\_\_\_

Telephone No.: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_  Receive Monthly Statements  Submit Requests for Disbursements

Address: \_\_\_\_\_

Telephone No.: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_  Receive Monthly Statements  Submit Requests for Disbursement

Address: \_\_\_\_\_

Telephone No.: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

## **11. Supplemental Information:**

List one contact to receive the Beneficiary Welcome Packet: \_\_\_\_\_

List one contact to receive the annual tax information: \_\_\_\_\_

***Note: Must be the Beneficiary or an authorized contact listed above.***

## **12. Monthly Statements:**

Should the Beneficiary receive a copy of the monthly statement? Yes  No

## **13. Representative:**

List the individual/firm who is responsible for submitting the Trust documents to Medicaid, Social Security Administration, or other government agency on the Beneficiary's behalf.

***Note: The individual listed below will receive a copy of the acceptance letter and a copy of the executed Joinder Agreement.***

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Agency/Firm, etc.: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

## **14. Referral Source:** Same as Representative submitting documents

***How did you hear about NYSARC Trust Services?***

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Agency/Firm, etc.: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

## **15. Funeral Provisions:**

Does the Beneficiary have funeral provisions in place? Yes  No

***If yes, please provide details (e.g. funeral home, plot location, etc.)***

## **Information and Disclosures:**

### **Assignment to Community Trust I or Community Trust II:**

NYSARC, Inc. retains the right to assign an account under this Joinder Agreement to either Community Trust I or Community Trust II based upon its classification as a “Pass-Through” account. A “Pass-Through” account is defined as any account where the beneficiary will be depositing a monthly income spend-down.

### **Community Trust I versus Community Trust II:**

Donor understands that Community Trust I and Community Trust II are identical in all **material** respects with the exception of fees. Fees assessed under Community Trust II may be higher due to the greater administrative costs associated with administering “Pass-Through” accounts. Donor acknowledges that he/she has reviewed the respective fee schedules of Community Trust I and Community Trust II and has no objection to NYSARC, Inc. assigning him/her to Community Trust II if the account is determined by NYSARC, Inc. to be a “Pass-Through” account.

### **Death of Beneficiary:**

- a. **The Beneficiary’s sub-trust account terminates upon his or her death.** If, upon the death of the Beneficiary, funds remain in his or her sub-trust account, such funds shall be deemed to be property of the Trust and all funds that are remaining in the Beneficiary’s separate sub-trust account shall be retained by the applicable **NYSARC, Inc. Community Trust** to further the purposes of that Trust. However, to the extent that amounts remaining in the individual’s sub-trust account upon the death of the individual are not in fact retained by the Trust, the Trust shall pay to the State(s) from such remaining amounts in the sub-trust account an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan(s). To the extent that the trust does not retain the funds in the account, the State(s) shall be the first payee(s) of any such funds and the State(s) shall have priority over payment of other debts and administrative expenses except as listed in the POMS [SI 01120.203.E](#).
- b. Funeral expenses can only be paid pursuant to a Medicaid eligible pre-need funeral arrangement established and funded prior to the Beneficiary’s death. **Funeral expenses cannot be paid after the Beneficiary’s death.**

### **Contributions/Deposits:**

- a. All contributions made to the sub-trust account will be held and administered pursuant to the provisions of the applicable **NYSARC, Inc. Community Trust I or II** which are incorporated by reference herein.
- b. The Trustees shall have the sole and absolute right to accept or refuse additional deposits to the sub-trust account.
- c. In the event that a Beneficiary has a zero (\$0) sub-trust account balance for sixty (60) or more consecutive days, the Trustee shall retain the right to close the Beneficiary’s sub-trust account. Please be advised that the Trustee may continue to charge administrative fees for the management of the sub-trust account prior to its closure. In the event that a Beneficiary wishes to re-open a sub-trust account, the Beneficiary may be required to pay any outstanding administrative fees stemming

from the prior sub-trust account. Additionally, the Beneficiary shall be required to pay a new enrollment fee when re-opening a sub-trust account.

Disbursements:

- a. All disbursement requests shall be reviewed and approved on an individual basis.
- b. Disbursements for expenses incurred more than ninety (90) days prior to submission of a disbursement request form shall not be paid.
- c. The Trustees, in their discretion, have determined that disbursements for the following items shall not be paid: purchases of firearms, alcohol or tobacco, items relating to illegal activity, bail, or restitution.
- d. All disbursements shall be made at the sole and absolute discretion of the Trustee.
- e. No disbursements can be made after the death of the Beneficiary, even for expenses incurred or due prior to death.

Disability Determination:

In the event that a determination of disability is required for Medicaid purposes, please be advised that administrative fees shall be incurred while the determination of disability is being made.

Taxes:

- a. The Donor acknowledges that contributions to the **NYSARC, Inc. Community Trusts** are not tax deductible as charitable gifts, or otherwise.
- b. Sub-trust account income may be taxable to the Beneficiary.

Disclosure of Potential Conflict of Interest:

There may be a potential conflict of interest in the administration of the Trust since the Trust retains those funds remaining in the sub-trust account at the time of death of the Beneficiary. Funds remaining in the Trust may be used to pay for ancillary and/or supplemental services for Beneficiaries and potential Beneficiaries for which services may be rendered by a **Chapter of NYSARC, Inc.** or by **NYSARC, Inc.** itself.

The Donor(s) executing this Joinder Agreement is/are aware of the potential conflicts of interest that exist in the Trustee's administration of the Trust. The Trustee shall not be liable to Donor or to any party for any act of self-dealing or conflict of interest resulting from their affiliations with **NYSARC, Inc.** or with any Beneficiary or constituent agencies and/or Chapters.

Situs:

The sub-trust account created by this Agreement has been accepted by the Trustee in the State of New York and will be administered by **NYSARC, Inc.** and a financial institution in the State of New York. The validity, construction, and all rights under this Agreement shall be governed by the laws of the State of New

York. The situs of this Trust for administrative, account and legal purposes shall be in the County of Albany, the County where the majority of meetings concerning establishment of the Trust occurred.

Invalidity of any Provision:

Should any provision of this Agreement be or become invalid or unenforceable, the remaining provisions of this Agreement shall be and continue to be fully effective.

**By signing below, you affirm that you understand and agree to the following:**

**I have received and read a copy of the applicable Master Trust prior to the signing of this *Joinder Agreement* and acknowledge that I understand the contents thereof. I also understand that said document may be amended from time to time. I have been provided with the applicable fee schedule and the Information & Procedures narrative and acknowledge that I understand the contents thereof. I also understand there may be changes from time to time.**

**I am entering into this Joinder Agreement voluntarily and acting on my own free accord.**

**The Donor acknowledges that the Beneficiary is disabled as defined in Social Security Law Section 1614(a)(3) [42 USC 1382c(a) (3)].**

**Under penalty of perjury, all statements made in this document are true and accurate to the best of my knowledge.**

**The NYSARC, Inc. Community Trust I and II are trusts authorized to be used by individuals with disabilities pursuant to federal and state law. By agreeing to accept a donor's property pursuant to this Joinder Agreement, NYSARC, Inc. agrees only to manage the trust funds in accordance with the terms of the Master Trust Agreement and in compliance with applicable federal and state law and regulation. It is the sole responsibility of the donor and/or the donor's representative to determine whether the donor is "disabled" as that term is defined under federal law, to determine whether they have the legal authority to transfer property to fund the trust, and the impact that a transfer of property to the NYSARC, Inc. Community Trust will have on the donor's continuing eligibility for government benefit programs.**

**NYSARC, Inc. is not assuming any responsibility as counsel for the donor or Beneficiary, or providing any legal advice as it relates to the consequences of a transfer of property to the NYSARC, Inc. Community Trust.**

**The Trustees in their discretion may require an intermediary to assist in the administration of the Beneficiary's sub-trust account. The cost of which may be charged to the sub-trust account.**

**The party authorized to speak with us on your behalf or the intermediary must notify NYSARC, Inc. immediately upon your death and will be required to provide us with a certified death certificate.**

**An individual requesting and/or receiving disbursements in contravention of the Master Trust Agreement and the Joinder Agreement will be required to repay the amount disbursed.**

**This Joinder Agreement and the participation of the Beneficiary in the NYSARC Community Trust is an important legal decision that may have significant and lasting consequences for the Beneficiary and as a result you may want to consider obtaining advice from an attorney or another professional adviser before entering into this Agreement. By signing this Agreement you are acknowledging that**

**you have had a full and complete opportunity to confer with an attorney or other adviser and that no employee of NYSARC, Inc. has provided you (or the Beneficiary, if different from the person signing this Agreement) with any legal advice in connection with this Joinder Agreement, the participation by the Beneficiary in the Community Trust or the suitability of such participation by the Beneficiary in the Community Trust based upon the particular circumstances of the Beneficiary.**

---

Signature of Donor/Guardian

Relationship to Beneficiary

Date

State of New York )  
County of \_\_\_\_\_ ) ss.

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned, a Notary Public in and for said State, personally appeared, \_\_\_\_\_ Personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within the instrument and acknowledged to me that he/she executed the same in his/her capacity and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed this instrument.

---

Notary Public

**If applicable, this document was translated by:**

---

Print Name

---

Sign

[Note: I submitted the Joinder. I still need to send documentation of the NYSARC trust once it is created.]

## **B. Irrevocable Funeral Trust**

### **Transfer to Irrevocable Funeral Trust**

---

Exempt Asset Transfer.

[official check to funeral home / PrePlan]

## Pre Need Itemization Statement

\*Do not use commas when entering dollar amounts.

**Firm Name**

Address 1

Address 2

City/State/Zip

---



---



---

PrePlan Acct #

Phone

**Ben. Name**

Address 1

Address 2

City/State/Zip

---



---



---

Prearrangement

Phone

**I. FUNERAL HOME CHARGES** (Indicate N/A for items of service and/or merchandise that were declined and TBS for items of service and/or merchandise to be selected at a later date.)

A. Alternative Services

- |                           |                         |
|---------------------------|-------------------------|
| 1. Direct Cremation       | \$ <input type="text"/> |
| 2. Direct Burial Services | \$ <input type="text"/> |

B. Transfer of remains to the funeral establishment, including personnel, equipment and vehicle

\$

C. Preparation of Remains

- |  |                         |
|--|-------------------------|
| 1. Embalming (including use of preparation room) | \$ <input type="text"/> |
|--|-------------------------|

If you select a funeral for which this firm requires embalming, such as a funeral with viewing, you may have to pay for embalming. You do not have to pay for embalming you do not approve if you select arrangements such as direct cremation or direct burial. If we charge for embalming, we will explain why later in "IV. Explanation of Charges."

2. Other Preparation (including use of preparation room but excluding embalming)

- |                         |                         |
|-------------------------|-------------------------|
| a. Topical Disinfection | \$ <input type="text"/> |
| b. Custodial Care       | \$ <input type="text"/> |
| c. Dressing/Casketing   | \$ <input type="text"/> |
| d. Cosmetology          | \$ <input type="text"/> |
| e. Restoration          | \$ <input type="text"/> |
| f. Other                | \$ <input type="text"/> |

specify:

D. Arrangements

\$

Basic arrangements: including funeral director, other staff, equipment and facilities to respond to initial request for service, the arrangement conference, securing of necessary authorizations and coordination of service plans with parties involved in the final disposition of the deceased.

E. Supervision (funeral director and staff)

- |                                    |                         |
|------------------------------------|-------------------------|
| 1. Supervision for visitation      | \$ <input type="text"/> |
| 2. Supervision for funeral service | \$ <input type="text"/> |
| 3. Other supervision               | \$ <input type="text"/> |

specify:

F. Use of the Facilities

- |  |                         |
|--|-------------------------|
| 1. Use of the facilities for visitation  | \$ <input type="text"/> |
| 2. Use of facilities for funeral service | \$ <input type="text"/> |
| 3. Other use of facilities               | \$ <input type="text"/> |

specify:

G. Livery

- |  |                         |
|--|-------------------------|
| 1. a. Hearse or<br>b. Alternative vehicle                            | \$ <input type="text"/> |
| specify: <input type="text"/>  | \$ <input type="text"/> |
| 2. Flower vehicle  | \$ <input type="text"/> |
| 3. Limousine(s) # <input type="text"/> @ \$ <input type="text"/>     | \$ <input type="text"/> |
| 4. Passenger car(s) # <input type="text"/> @ \$ <input type="text"/> | \$ <input type="text"/> |

H. Merchandise

- |                                    |                         |
|------------------------------------|-------------------------|
| 1. Casket or Alternative Container | \$ <input type="text"/> |
|------------------------------------|-------------------------|

a. Supplier   
b. Model name or #   
c. Material: wood   
or kind of metal   
weight or gauge   
or alternative container   
describe   
d. Interior

- |                               |                         |
|-------------------------------|-------------------------|
| 2. Outer Interment Receptacle | \$ <input type="text"/> |
|-------------------------------|-------------------------|

a. Supplier   
b. Model name or #   
c. Material

## Pre Need Itemization Statement Page 2

### I. Additional Services and Merchandise Selected (Describe and show price)

1. Memorial Cards	\$ _____
2. Acknowledgement Cards	\$ _____
3. Clothing or Burial Garments	\$ _____
4. Register Book	\$ _____
5. Death Notices	\$ _____
6.	\$ _____
7.	\$ _____
8.	\$ _____
9.	\$ _____
10.	\$ _____
11.	\$ _____
12.	\$ _____

### J. Limited Services (If this is selected, a basic arrangement charge cannot be separately billed.)

1. Forwarding remains to	\$ _____
2. Receiving remains from	\$ _____

### TOTAL FUNERAL HOME CHARGES \$ \_\_\_\_\_

### II. CASH ADVANCES. These are estimated charges for items at current rates to be paid to others. We will charge you no more for these items than will actually be paid the third parties when the death occurs. (Describe and show estimated charges)

1. Cemetery / Crematory:	\$ _____
2. Clergy Honoraria:	\$ _____
3. Death Certificate Transcripts # _____ @ \$ _____	\$ _____
4. Livery	\$ _____
5. Pallbearers	\$ _____
6. Public Transportation	\$ _____
7. Gratuities	\$ _____
8. Bridge & Road Tolls	\$ _____
9.	\$ _____
10.	\$ _____
11.	\$ _____
12.	\$ _____

13.	\$ _____
14.	\$ _____
15.	\$ _____

### ESTIMATED TOTAL OF CASH ADVANCES \$ \_\_\_\_\_

III. SUMMARY OF CHARGES	\$ _____
1. Total of Funeral Home Charges	\$ _____
2. Estimated Total of Cash Advances	\$ _____
3. Allowance	\$ ( _____ )

### TOTAL FUNERAL CHARGES \$ \_\_\_\_\_

IV. EXPLANATION OF CHARGES. Explain charges for embalming and for any items that are not required by law but may be necessary because of cemetery requirements, crematory requirements or other selections made.

Total Charge For Use of Facilities and Staff:

1. For Visitation (E1 + F1)	\$ _____
2. For Funeral Service (Ceremony) (E2 + F2)	\$ _____

### V. ADDTL. INSTRUCTIONS TO THE FUNERAL DIRECTOR

x  
Signature of Licensed Funeral Director Date

Printed Name of Licensed Funeral Director

Funeral Director Registration # \_\_\_\_\_  
Funeral Firm Registration # \_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT.

I have received this itemization of funeral services and merchandise selected. \*

x

Signature of Purchaser

Date

PUBLIC NOTICE: The New York State Department of Health is responsible for licensing and regulating New York State funeral directing under the Public Health Law. You may contact the Department at: Bureau of Funeral Directing, 875 Central Ave. Albany, NY 12206

\* I have received a copy of the current general price list and reviewed the casket and outer interment receptacle price list if appropriate for my selections.

Important Note: The use of this form is limited to authorized funeral directors who are participants in the New York State Funeral Directors Association PrePlan Trust Program. Deposit of funds into any investment vehicle other than the PrePlan trust fund will nullify the enclosed trust disclosures and trust agreement. Any use of this form by an unauthorized funeral director will be prosecuted by the NYSFDA PrePlan Trust to the fullest extent of the law.

## **IRREVOCABLE/MEDICAID PRENEED AGREEMENT**

### **GUARANTEED PRICE EXCLUDING CASH ADVANCES**

<b>Funeral Firm (NYS registered funeral firm)</b>		
<b>Funeral Firm Name:</b>		PrePlan Account #:
<b>Funeral Director Name:</b>		
Street:		Phone:
City:		NY
Date:	Place:	Zip:
<b>Prearrangement #:</b>		
<b>Replacement of Existing Revocable Customer Agreement</b> Yes No		
<b>If YES, Preplan Consumer Account #:</b>		
<b>Beneficiary</b> (person for whom preneed arrangements are being made)		SS#
Name of Beneficiary:		Phone:
INTENTIONALLY LEFT BLANK		Email:
Street:		Apt. / Suite:
City:		State: Zip:
Check Beneficiary Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Beneficiary Date of Birth:
<b>Purchaser</b> (person funding account)		<input type="checkbox"/> Check if same as beneficiary
Name of Purchaser:		Phone:
INTENTIONALLY LEFT BLANK		Email:
Street:		Apt. / Suite:
City:		State: Zip:
<b>Amount Received:</b> \$ _____ <b>Payment Type:</b> <input type="checkbox"/> cash <input type="checkbox"/> check # _____ <input type="checkbox"/> credit card <input type="checkbox"/> ACH <input type="checkbox"/> other _____		
<b>Alternate Person</b>		
<input type="checkbox"/> <b>I decline to provide an alternate person</b>		
<b>Alternate Name:</b>		Phone:
INTENTIONALLY LEFT BLANK		Email:
Street:		Apt. / Suite:
City:		State: Zip:
<b>Correspondence (If no one is selected, all confirmations will be mailed to the Purchaser)</b>		
Send correspondence to (select one): <input type="checkbox"/> Beneficiary <input type="checkbox"/> Purchaser <input type="checkbox"/> Alternate Person		
<b>Total Funeral Charges</b>		
Total Funeral Home Charges: \$ _____		
Total Cash Advances: \$ _____		
The total funeral charges set forth in the Preneed Itemization Statement is \$ _____		
<p><b>DISCLOSURE.</b> NEW YORK LAW REQUIRES THIS AGREEMENT TO BE IRREVOCABLE FOR APPLICANTS FOR AND RECIPIENTS OF SUPPLEMENTAL SECURITY BENEFITS UNDER SECTION TWO HUNDRED NINE OF THE SOCIAL SERVICES LAW OR OF MEDICAL ASSISTANCE UNDER SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW, AND FOR THE MONIES PUT INTO A TRUST UNDER THIS AGREEMENT TO BE USED ONLY FOR FUNERAL AND BURIAL EXPENSES. WHETHER THE AGREEMENT IS FOR YOUR FUNERAL AND BURIAL EXPENSES OR FOR THOSE OF A FAMILY MEMBER, IF ANY MONEY IS LEFT OVER AFTER YOUR FUNERAL AND BURIAL EXPENSES HAVE BEEN PAID, IT WILL GO TO THE COUNTY. YOU MAY CHANGE YOUR CHOICE OF FUNERAL HOME AT ANY TIME. IF THIS AGREEMENT IS FOR THE FUNERAL AND BURIAL EXPENSES OF A FAMILY MEMBER, AFTER YOUR DEATH SUCH FAMILY MEMBER MAY CHANGE THE CHOICE OF FUNERAL HOME AT ANY TIME.</p>		

**Definitions.**

*PrePlan.* The preneed funeral services trust established in accordance with Section 453 of New York General Business Law  
*Agreement.* This preneed agreement between the Purchaser and Funeral Firm

*Beneficiary.* The person upon whose death funeral services and merchandise are to be provided under the terms of a preneed agreement  
*Purchaser.* The person who has provided funds to a Funeral Firm under or in conjunction with a preneed agreement for a Beneficiary

*Alternate Person.* The person not residing at the same address as the Purchaser to whom required notices will be sent if the Purchaser or Beneficiary cannot be contacted

*Funeral Firm.* The party named in this Agreement, as funeral firm, which must be a New York State registered funeral firm

*Account.* The account established for depositing and investing funds for the Beneficiary under the Agreement

*Preneed Itemization Statement.* The statement of funeral services and merchandise

*Trustees.* The trustees of the PrePlan Funeral Trust

*Administrator.* Funeral Director Support Services, Inc. (FDSS), a wholly owned subsidiary of the New York State Funeral Directors Association

*Association.* The New York State Funeral Directors Association

**Purpose of this Agreement and the Funeral Arrangements.** The purpose of this Agreement is to establish a place and method for the deposit and administration of money paid now to be used later for funeral expenses. The Funeral Firm and the Purchaser have made funeral arrangements for the Beneficiary, with the current prices for same being provided on the Preneed Itemization Statement.

**Price Guarantee.** The Funeral Firm guarantees that upon the death of the Beneficiary the services and merchandise specified in the Preneed Itemization Statement, excluding cash advances as listed in Roman Numeral II, will be provided at prices not to exceed the total of the funds deposited under this Agreement plus accrued interest and/or dividends, provided that the deposit received is equal to the Total Funeral Charges under Roman Numeral III of the Preneed Itemization Statement. This price guarantee will be valid only if the original deposit and subsequent accrued interest and/or dividends remain in the account and if there are otherwise no charges or liens outstanding against such funds. Should the total amount of the funds held pursuant to this Agreement at the time of the provision of the services and merchandise for the Beneficiary exceed the total price for such services and merchandise based upon the prices then being charged to the general public by the Funeral Firm, any such surplus shall be paid by the Funeral Firm to the Social Services official responsible for arranging for indigent burials in the county where the Beneficiary resided.

**Cash Advances Excluded from the Price Guarantee.** Items described as cash advances on the Preneed Itemization Statement under Roman Numeral II, are specifically excluded from the price guarantee provisions of this Agreement. The Funeral Firm's only obligation under this Agreement with respect to cash advances is to credit the amount of money received under this Agreement for cash advances, and any accumulated interest or dividends attributable to that amount over time, to the actual future cost of those cash advances at the death of the Beneficiary. If at that time the proceeds attributable to cash advances are in excess of the actual prices, such surplus will be paid by the Funeral Firm to the Social Services official responsible for arranging for indigent burials in the local government subdivision where the Beneficiary resided at the time of death. If the proceeds attributable to cash advances are less than the actual prices, then the Purchaser or his legal representative will need to supplement the payments to the Funeral Firm to cover the difference or otherwise modify the selection of cash advances.

**When the Price Guarantee Becomes Voidable by the Funeral Firm.** In the event that any portion of the original deposit and all subsequent accrued interest and/or dividends are not maintained in an entirely intact manner, then the price guarantee provided by the Agreement shall be void, and the Funeral Firm will calculate the actual prices being charged to the public at the time of performance and the Purchaser or his legal representative shall have the option of paying any difference between the price calculated by the Funeral Firm and the funds available or modifying the arrangements.

**Applicability of Insurance Coverage.** Investments of the Trust are either issued by the federal government or insured by agencies of the federal government up to the maximum coverage available to the Purchaser. In accordance with the agencies' insurance rules, other bank accounts of the Purchaser held at the same bank, credit union or trust company which serves as depository for the PrePlan may be considered with the account of the Purchaser held in the PrePlan for the purposes of determining the amount of available insurance coverage.

**Relationship Between the Funeral Firm and the PrePlan.** The Funeral Firm has retained the trust administration services of the PrePlan for the purposes of holding and managing advance funeral payments received by the Funeral Firm. This relationship is governed by a trust agreement between the Funeral Firm and the Trustees. Under the trust agreement, the Funeral Firm has no authority to change or modify any portion of this Agreement or promise to do anything on behalf of the Trustees. Similarly, neither the Trustees nor any of its agents are responsible for performing any of the services or supplying any of the merchandise specified by the Preneed Itemization Statement completed by the Purchaser and the Funeral Firm.

**Limitations of Liability.** Responsibility of the Trustees, the Association and the Administrator and their officers, agents and employees under this Agreement is restricted to the performance of the trust administration services specified in this Agreement and the underlying trust agreement between the Funeral Firm and the Trustees under which the monies are held. In no event shall the Trustees be liable for more than the amount of the funds received by them, and accumulated income thereon. All deposits into the PrePlan must be in connection with a preneed agreement. Deposits will be provisionally credited until funds have cleared. The PrePlan shall not be liable for any returned items. The PrePlan reserves the right to refuse to accept any deposit.

**Right to Change Depository.** The Trustees retain the right to change the bank, credit union or trust company where they maintain the PrePlan accounts and investments. In the event there is a change in the institution in which funds are deposited, the Purchaser will receive written notification of that fact within thirty (30) days after the change in the institution.

**Administration and Fees.** FDSS is paid a fee for maintaining the PrePlan and for performing certain functions on behalf of the Trustees. The fee is equal to seventy-five hundredths of one percent based upon the average daily balance in the PrePlan. An additional investment advisory fee may be paid to an unrelated professional investment manager by the PrePlan.

**Information and Reports and Tax Responsibility.** Within thirty (30) business days after a payment has been received for deposit in the PrePlan, the Purchaser will receive an acknowledgement of the amount of the deposit, the account number assigned and the institution holding the deposit. The opening of the Account is subject to the collection of funds deposited. Following the end of each calendar year, the Purchaser will receive a statement showing any activity in the Account for the past year including interest credited and the location of the deposits. The Purchaser will also receive a tax reporting statement showing the total interest earned. All income or other taxes payable on the interest shall be the responsibility of the Purchaser.

**Merchandise and Service Substitution.** In the event that service or merchandise specified in the Preneed Itemization Statement cannot be provided at the time of performance, the Funeral Firm may substitute merchandise of substantially equal quality, value and workmanship and may provide substitute personnel to perform substantially similar services as specified in the Preneed Itemization Statement, in consultation with the Purchaser or his legal representative.

**Payments to the Purchaser.** This Agreement may be used only for those intended funeral recipients (Beneficiaries) who are applicants for or recipients of benefits from either the Supplemental Security Income (SSI) and/or Medicaid Program, or any extensions thereof, as provided by the US Department of Health and Human Services, Social Security Administration [(42USCS § 1382b et seq.) and (20 CFR 416.1231)] and Subdivision 6 of Section 209 of the New York State Social Services Law, and Title II, Medical Assistance, Article 5, Section 366 of the New York State Social Services Law or for specific family members as allowed by New York State law. Under these programs, the deposit and any accrued interest may not be returned to the Purchaser and may only be used as payment for the funeral of the Beneficiary.

**Meaning of Irrevocability.** The acceptance of this Agreement creates an irrevocable trust which means that any attempted withdrawal or other disposition of the deposits on account plus accrued interest, for any purpose, will be and must legally be refused by the Funeral Firm, the Trustees, the PrePlan and any officer, employee or agent. Completion of this Agreement shall constitute an itemized contract for future delivery of the merchandise specified or its comparable substitute, subject to other provisions of this Agreement.

**Irrevocability, Severability and Portability.** This Agreement is not revocable in any manner. However, the funeral arrangements are fully severable from this Agreement, and can be changed from time to time and at any time, and such changes can include the Purchaser's selection of a different Funeral Firm.

**Right to Statements on Request.** Within thirty (30) days of a request by the Purchaser or his legal representative, the Purchaser will be provided with a statement identifying the location of the Account in which the deposit is maintained, the Account balance and interest earned.

**Payments to the Funeral Firm.** Any deposit or deposits along with interest earned will be payable to the Funeral Firm upon presentation of a certified death certificate of the Beneficiary.

**Failure to Perform.** If the Funeral Firm cannot, for reasons beyond the control of the parties, provide the funeral services or merchandise contemplated in conjunction with this Agreement, then the Purchaser's sole remedy shall be the selection of a different funeral firm by the Purchaser or the Beneficiary's legal representative.

**Successor Rights.** In the event the Purchaser predeceases the Beneficiary where they are different persons, then the Beneficiary shall automatically assume all rights with respect to the Account as Purchaser. And, upon the death of the Beneficiary where the Purchaser is no longer living, the right to administer the Account shall pass to the person entitled to control the funeral of the Beneficiary in order of priority provided by law or any succeeding statute. For the purposes of this Agreement, where the Purchaser has predeceased the Beneficiary then Purchaser shall mean the Beneficiary or his or her successors as specified in this paragraph.

**General.** The Trustees shall not be liable for any damages incurred by the Purchaser or the Funeral Firm resulting from any false, incorrect, incomplete or misleading information provided to the Trustees or the Funeral Firm by the Purchaser nor shall the Trustees be liable for acting or failing to act when in good faith, they rely upon the genuineness of documents or signatures submitted to them.

---

**Request for Social Security Number and Certification**

Purchaser's Social Security #: \_\_\_\_\_

Purchaser/Taxpayer's Name: \_\_\_\_\_

Certification - Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct taxpayer identification number, and
- (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

**Certification Instructions** - You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

**PLEASE SIGN HERE: (X)** \_\_\_\_\_ DATE \_\_\_\_\_  
Signature of Purchaser/Taxpayer (person whose SS# appears above)

---

**Deposit Acknowledgement.** The Funeral Firm acknowledges receipt of the amount set forth on page 1 of this Agreement on account for the funeral goods and services to be delivered upon the death of the Beneficiary. The Funeral Firm agrees to deposit this sum in the PrePlan depository within ten (10) business days. The deposit shall be maintained in commingled accounts in the name of the PrePlan Trust, and a separate account on the books and records of the PrePlan shall be established in the name of the Purchaser, indicating the beneficial interest of the Beneficiary. All credits to and deductions from the deposit shall be held by the PrePlan and reflected on the Account. Money received under this Agreement will be held in bank deposit account(s) or certificates of deposit insured by agencies of the federal government within the State of New York and other investments permitted by law. Checks should be made payable to 'PrePlan'.

**Acceptance.** I have read the terms and conditions of the "Pre Need Irrevocable Customer Agreement" and I expressly intend to obligate myself to them, and at the same time to acknowledge that the information provided above and within this Agreement is correct. Further, I attest that I am or the Beneficiary is an applicant for or recipient of SSI/Medicaid.

Purchaser's Signature \_\_\_\_\_

Funeral Director's Signature (on behalf of Funeral Firm) \_\_\_\_\_

# PART 5

## Verification of Past Sources

### Contents

Summary of Funds Origin . . . . .	98
A. Inheritance . . . . .	99
Notification letter for life insurance payout . . . . .	99
Mother momfirstname Lastname' death certificate . . . . .	99
1099-R . . . . .	99
B. Opening Bankname Deposit (Life savings) . . . . .	100
C. Tax Returns . . . . .	101
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Check #xxx: Federal Tax Payment (Tax Due) . . . . .	103
CP12: IRS Refund / Correction Notice, tax year [year] . . . . .	104
IT-201: New York State tax return, tax year (year) . . . . .	104

## **Summary of Funds Origin**

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This section provides documentation for large historical deposits identified in the 5-year lookback period.

### **A. Inheritance (\$xxxxx.xx)**

*Date: Month day, [year]*

Proceeds from the Bankname3 Life Insurance policy of the applicant's mother, momfirstname Lastname. (See Exhibit A, p. 99).

### **B. Opening Bankname Deposit (\$xxxxx.00)**

*Date: Month day, year*

Deposit slip establishing the starting balance of the Bankname account. Represents accumulated cash savings prior to account opening. (See Exhibit B, p. 100).

### **C. [year] Tax Returns**

*Date: [following year] Tax Season*

- **Federal (1040, p. 101):** Refund Issued.

*Note: The attached 1040 contains a calculation error which was subsequently corrected by the IRS. (See Correction Notice, p. 104).*

- **NYS (IT-201, p. 104):** Tax liability \$xxxx paid in full.

*Note: Liability initially paid by Daughtername Lastname. (See Part 3 A, p. 67 for reimbursement documentation).*

The 1099 documents are available:

- Inheritance, p. 99
- SSDI, p. 61

*Other than [the one year], taxes were not filed for recent years.*

*Supporting documentation follows on next pages.*

[Bankname3 inheritance letter]

[death certificate to show why applicant received inheritance]

[1099 for receiving the inheritance]

[printouts from the bank showing documentation of the opening deposit]

For the year Jan. 1-Dec. 31, 2024, or other tax year beginning _____, 2024, ending _____, 20_____		See separate instructions.		
Your first name and middle initial	Last name	Your social security number		
If joint return, spouse's first name and middle initial	Last name	Spouse's social security number		
Home address (number and street). If you have a P.O. box, see instructions.		Apt. no.	Presidential Election Campaign	
City, town, or post office. If you have a foreign address, also complete spaces below.		State	ZIP code	
Foreign country name	Foreign province/state/county	Foreign postal code	Check here if you, or your spouse if filing jointly, want \$3 to go to this fund. Checking a box below will not change your tax or refund. <input type="checkbox"/> You <input type="checkbox"/> Spouse	
<b>Filing Status</b>	<input type="checkbox"/> Single <input type="checkbox"/> Head of household (HOH) <input type="checkbox"/> Married filing jointly (even if only one had income) <input type="checkbox"/> Qualifying surviving spouse (QSS) <input type="checkbox"/> Married filing separately (MFS) <p>If you checked the MFS box, enter the name of your spouse. If you checked the HOH or QSS box, enter the child's name if the qualifying person is a child but not your dependent: _____</p> <p><input type="checkbox"/> If treating a nonresident alien or dual-status alien spouse as a U.S. resident for the entire tax year, check the box and enter their name (see instructions and attach statement if required): _____</p>			
<b>Digital Assets</b>	At any time during 2024, did you: (a) receive (as a reward, award, or payment for property or services); or (b) sell, exchange, or otherwise dispose of a digital asset (or a financial interest in a digital asset)? (See instructions.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Standard Deduction</b>	<b>Someone can claim:</b> <input type="checkbox"/> You as a dependent <input type="checkbox"/> Your spouse as a dependent <input type="checkbox"/> Spouse itemizes on a separate return or you were a dual-status alien			
<b>Age/Blindness</b>	You: <input type="checkbox"/> Were born before January 2, 1960 <input type="checkbox"/> Are blind	Spouse: <input type="checkbox"/> Was born before January 2, 1960 <input type="checkbox"/> Is blind		
<b>Dependents</b> <small>(see instructions)</small> If more than four dependents, see instructions and check here . . . <input type="checkbox"/>	(1) First name    Last name	(2) Social security number	(3) Relationship to you	(4) Check the box if qualifies for (see instructions): Child tax credit    Credit for other dependents
				<input type="checkbox"/>
<b>Income</b>	1a Total amount from Form(s) W-2, box 1 (see instructions) . . . . . b Household employee wages not reported on Form(s) W-2 . . . . . c Tip income not reported on line 1a (see instructions) . . . . . d Medicaid waiver payments not reported on Form(s) W-2 (see instructions) . . . . . e Taxable dependent care benefits from Form 2441, line 26 . . . . . f Employer-provided adoption benefits from Form 8839, line 29 . . . . . g Wages from Form 8919, line 6 . . . . . h Other earned income (see instructions) . . . . . i Nontaxable combat pay election (see instructions) . . . . . z Add lines 1a through 1h . . . . .	1a 1b 1c 1d 1e 1f 1g 1h 1i		
Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld. If you did not get a Form W-2, see instructions.	2a Tax-exempt interest . . . . . 3a Qualified dividends . . . . . 4a IRA distributions . . . . . 5a Pensions and annuities . . . . . 6a Social security benefits . . . . .	2a 3a 4a 5a 6a	b Taxable interest . . . . . b Ordinary dividends . . . . . b Taxable amount . . . . . b Taxable amount . . . . . b Taxable amount . . . . .	
Attach Sch. B if required.	c If you elect to use the lump-sum election method, check here (see instructions) . . . . . 7 Capital gain or (loss). Attach Schedule D if required. If not required, check here . . . . . 8 Additional income from Schedule 1, line 10 . . . . . 9 Add lines 1z, 2b, 3b, 4b, 5b, 6b, 7, and 8. This is your <b>total income</b> . . . . . 10 Adjustments to income from Schedule 1, line 26 . . . . . 11 Subtract line 10 from line 9. This is your <b>adjusted gross income</b> . . . . . 12 Standard deduction or itemized deductions (from Schedule A) . . . . . 13 Qualified business income deduction from Form 8995 or Form 8995-A . . . . . 14 Add lines 12 and 13 . . . . . 15 Subtract line 14 from line 11. If zero or less, enter -0-. This is your <b>taxable income</b> . . . . .	7 8 9 10 11 12 13 14 15		

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 11320B

Form 1040 (2024)

Go to [www.irs.gov/Form1040](http://www.irs.gov/Form1040) for instructions and the latest information.

---

Form **1040** (2024)

## **IRS Tax Payment (year Tax Year)**

---

*Note: Physical check #xxx (\$xxxx) mailed 4/15/year;  
processed electronically by IRS on 4/xx/year.*

[oops - made an arithmetic error, got a refund]



Department of Taxation and Finance

# Resident Income Tax Return

New York State • New York City • Yonkers • MCTMT

# IT-201

For the full year January 1, 2023, through December 31, 2023, or fiscal year beginning ... 23  
and ending ...

For help completing your return, see the instructions, Form IT-201-I.

Your first name	MI	Your last name (for a joint return, enter spouse's name on line below)	Your date of birth (mmddyyyy)	Your Social Security number
Spouse's first name	MI	Spouse's last name	Spouse's date of birth (mmddyyyy)	Spouse's Social Security number
Mailing address (see instructions) (number and street or PO Box)			Apartment number	New York State county of residence
City, village, or post office		State	ZIP code	Country
Taxpayer's permanent home address (see instructions) (number and street or rural route)			Apartment number	School district name
City, village, or post office		State	ZIP code	Taxpayer's date of death (mmddyyyy) Spouse's date of death (mmddyyyy)
		NY		Decedent information

**A Filing status**      ①  Single

- (mark an X in one box):  
 ②  Married filing joint return  
 (enter spouse's Social Security number above)  
 ③  Married filing separate return  
 (enter spouse's Social Security number above)  
 ④  Head of household (with qualifying person)  
 ⑤  Qualifying surviving spouse

**B Did you itemize** your deductions on  
 your 2023 federal income tax return? ..... Yes  No

**C Can you be claimed** as a dependent  
 on another taxpayer's federal return? ..... Yes  No

**D1** Did you have a financial account located  
 in a foreign country? ..... Yes  No

**D2** (1) Did you or your spouse **Maintain living quarters in Yonkers** for any part of 2023? ... Yes  No   
 If Yes:

(2) Number of months **you** lived in Yonkers in 2023 .....

(3) Number of months **your spouse** lived in Yonkers in 2023 .....   
 If No:

(4) Did you or your spouse work in Yonkers while  
 not living in Yonkers for any part of 2023 ..... Yes  No

**E** (1) Did you or your spouse **Maintain living quarters in NYC** (this includes the Bronx, Brooklyn, Manhattan, Queens, and Staten Island) during 2023? ..... Yes  No

(2) Enter the number of days spent in NYC in 2023  
 (any part of a day spent in NYC is considered a day).....

**F NYC residents and NYC part-year residents only:**

(1) Number of months **you** lived in NYC in 2023 .....

(2) Number of months **your spouse** lived in NYC in 2023 .....

**G** Enter your 2-character special condition  
 code(s) if applicable .....

**H Dependent information**

First name	MI	Last name	Relationship	Social Security number	Date of birth (mmddyyyy)

If more than 7 dependents, mark an X in the box.

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For office use only

Your Social Security number	

**Federal income and adjustments**

Whole dollars only

1 Wages, salaries, tips, etc.	<b>1</b>	.00
2 Taxable interest income	<b>2</b>	.00
3 Ordinary dividends	<b>3</b>	.00
4 Taxable refunds, credits, or offsets of state and local income taxes (also enter on line 25)	<b>4</b>	.00
5 Alimony received	<b>5</b>	.00
6 Business income or loss (submit a copy of federal Schedule C, Form 1040)	<b>6</b>	.00
7 Capital gain or loss (if required, submit a copy of federal Schedule D, Form 1040)	<b>7</b>	.00
8 Other gains or losses (submit a copy of federal Form 4797)	<b>8</b>	.00
9 Taxable amount of IRA distributions. If received as a beneficiary, mark an X in the box	<b>9</b>	.00
10 Taxable amount of pensions and annuities. If received as a beneficiary, mark an X in the box	<b>10</b>	.00
11 Rental real estate, royalties, partnerships, S corporations, trusts, etc. (submit copy of federal Schedule E, Form 1040)	<b>11</b>	.00
12 Rental real estate included in line 11	<b>12</b>	.00
13 Farm income or loss (submit a copy of federal Schedule F, Form 1040)	<b>13</b>	.00
14 Unemployment compensation	<b>14</b>	.00
15 Taxable amount of Social Security benefits (also enter on line 27)	<b>15</b>	.00
16 Other income (Identify):	<b>16</b>	.00
17 Add lines 1 through 11 and 13 through 16	<b>17</b>	.00
18 Total federal adjustments to income (Identify):	<b>18</b>	.00
19 Federal adjusted gross income (subtract line 18 from line 17)	<b>19</b>	.00

**New York additions**

20 Interest income on state and local bonds and obligations (but not those of NYS or its local governments)	<b>20</b>	.00
21 Public employee 414(h) retirement contributions from your wage and tax statements	<b>21</b>	.00
22 New York's 529 college savings program distributions	<b>22</b>	.00
23 Other (Form IT-225, line 9)	<b>23</b>	.00
24 Add lines 19 through 23	<b>24</b>	.00

**New York subtractions**

25 Taxable refunds, credits, or offsets of state and local income taxes (from line 4)	<b>25</b>	.00
26 Pensions of NYS and local governments and the federal government	<b>26</b>	.00
27 Taxable amount of Social Security benefits (from line 15) ...	<b>27</b>	.00
28 Interest income on U.S. government bonds	<b>28</b>	.00
29 Pension and annuity income exclusion	<b>29</b>	.00
30 New York's 529 college savings program deduction/earnings	<b>30</b>	.00
31 Other (Form IT-225, line 18)	<b>31</b>	.00
32 Add lines 25 through 31	<b>32</b>	.00
33 New York adjusted gross income (subtract line 32 from line 24)	<b>33</b>	.00

**Standard deduction or itemized deduction**34 Enter your **standard deduction** or your **itemized deduction** (from Form IT-196)Mark an X in the appropriate box:  Standard - or -  Itemized

<b>34</b>	.00
<b>35</b>	.00
<b>36</b>	<b>000.00</b>
<b>37</b>	.00

35 Subtract line 34 from line 33 (if line 34 is more than line 33, leave blank)	<b>35</b>	.00
36 Dependent exemptions (enter the number of dependents listed in item H)	<b>36</b>	<b>000.00</b>
37 Taxable income (subtract line 36 from line 35)	<b>37</b>	.00

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Name(s) as shown on page 1	Your Social Security number
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Your Social Security number
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**Tax computation, credits, and other taxes**

<b>38 Taxable income</b> (from line 37 on page 2) .....	<b>38</b>	.00
<b>39 NYS tax on line 38 amount</b> .....	<b>39</b>	.00
<b>40 NYS household credit</b> .....	<b>40</b>	.00
<b>41 Resident credit</b> .....	<b>41</b>	.00
<b>42 Other NYS nonrefundable credits</b> (Form IT-201-ATT, line 7) ...	<b>42</b>	.00
<b>43 Add lines 40, 41, and 42</b> .....	<b>43</b>	.00
<b>44 Subtract line 43 from line 39</b> (if line 43 is more than line 39, leave blank) .....	<b>44</b>	.00
<b>45 Net other NYS taxes</b> (Form IT-201-ATT, line 30) .....	<b>45</b>	.00
<b>46 Total New York State taxes</b> (add lines 44 and 45) .....	<b>46</b>	.00

**New York City and Yonkers taxes, credits, and surcharges, and MCTMT**

<b>47 NYC taxable income</b> .....	<b>47</b>	.00
<b>47a NYC resident tax on line 47 amount</b> .....	<b>47a</b>	.00
<b>48 NYC household credit</b> .....	<b>48</b>	.00
<b>49 Subtract line 48 from line 47a</b> (if line 48 is more than line 47a, leave blank) .....	<b>49</b>	.00
<b>50 Part-year NYC resident tax</b> (Form IT-360.1) .....	<b>50</b>	.00
<b>51 Other NYC taxes</b> (Form IT-201-ATT, line 34) .....	<b>51</b>	.00
<b>52 Add lines 49, 50, and 51</b> .....	<b>52</b>	.00
<b>53 NYC nonrefundable credits</b> (Form IT-201-ATT, line 10) .....	<b>53</b>	.00
<b>54 Subtract line 53 from line 52</b> (if line 53 is more than line 52, leave blank) .....	<b>54</b>	.00

See instructions to  
compute New York City and  
Yonkers taxes, credits, and  
surcharges.

<b>54a MCTMT net earnings</b> base for Zone 1..	<b>54a</b>	.00
<b>54b MCTMT net earnings</b> base for Zone 2..	<b>54b</b>	.00
<b>54c MCTMT for Zone 1</b> .....	<b>54c</b>	.00
<b>54d MCTMT for Zone 2</b> .....	<b>54d</b>	.00
<b>54e Total MCTMT</b> (add lines 54c and 54d) .....	<b>54e</b>	.00
<b>55 Yonkers resident income tax surcharge</b> .....	<b>55</b>	.00
<b>56 Yonkers nonresident earnings tax</b> (Form Y-203) .....	<b>56</b>	.00
<b>57 Part-year Yonkers resident income tax surcharge</b> (Form IT-360.1)	<b>57</b>	.00
<b>58 Total New York City and Yonkers taxes / surcharges and MCTMT</b> (add lines 54 and 54e through 57) .....	<b>58</b>	.00

See instructions to compute  
the MCTMT for each zone.

<b>59 Sales or use tax</b> (do not leave blank) .....	<b>59</b>	.00
<b>60 Voluntary contributions</b> (Form IT-227, Part 2, line 1) .....	<b>60</b>	.00
<b>61 Total New York State, New York City, Yonkers, and sales or use taxes, MCTMT, and voluntary contributions</b> (add lines 46, 58, 59, and 60) .....	<b>61</b>	.00

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