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NYS Office For People With Developmental Disabilities

Putting People First

Benefit Development Resource Guide

2014

Andrew M. Cuomo, *Governor*

Kerry Delaney, *Acting Commissioner*

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Introduction

About this Guide

The Benefit Development Resource Guide (Resource Guide) is designed to assist employees who are responsible for developing the benefits and entitlements necessary to fund services for individuals served by OPWDD and voluntary provider agencies. It is not intended to be read from cover to cover, though those new to the topics discussed may wish to do so. The Resource Guide is primarily intended to be used as a reference during the process of assisting individuals in developing the benefits necessary to fund their care.

This guide provides detailed information about conducting eligibility investigations, protecting assets, and applying for Medicaid, the OPWDD Home and Community Based Services (HCBS) Waiver, Supplemental Security Income (SSI), Social Security benefits (SSDI), Medicare, and the Supplemental Nutrition Assistance Program (SNAP – formerly called Food Stamps).

The manual consists of this introduction and the following sections:

- Benefit Development
- Liability for Services
- Medicaid
- Home and Community Based Services Waiver
- Supplemental Security Income
- Social Security Benefits
- Work Incentives
- Medicare
- Supplemental Nutrition Assistance Program
- Resource Management
- Additional Resources

Each benefit section includes a discussion of eligibility requirements, outlines application processes, and references important forms and information, many of which are included as attachments in the Additional Resources section.

Forms found in the Resource Guide are provided as samples for reference only; all efforts are made to include the latest versions available; however, it is the responsibility of personnel developing benefits to ensure they are using the most current versions of the forms, which may be obtained by contacting the benefit-paying agency. A list of Local Departments of Social Services and their contact information is included in the Additional Resources section (Local Departments of Social Services, page 185). To locate the Social Security office that serves your area, a local office search by zip code

can be done on the Social Security Administration website (www.ssa.gov or www.socialsecurity.gov). Many of the forms may be also be accessed online.

Benefit Development

When a person applies for services, it is important for agency staff to look at the person's income and resources, to gather all the information needed to obtain and maintain benefits for the person, to assist the person and/or his or her family in applying for any additional benefits to which the person may be entitled, and to notify appropriate benefit-paying agencies of changes in the person's financial situation or address. The timing of benefit-related actions, including applications and change reporting, is critical to an agency's operations because SSI eligibility is not retroactive and the maximum retroactivity for Medicaid is three months; therefore, if actions are not taken timely, the result could be the loss of benefits for the individual and loss of revenue for the agency.

Agency Responsibilities

Prompt and thorough completion of benefit development actions protects and supports the individual as well as the service provider. Applying for Medicaid coverage and HCBS Waiver enrollment and carrying out the actions needed to maintain Medicaid coverage, such as recertification, allows the person to obtain needed services and facilitates provider payments for those services. Because of this, it is strongly recommended that each voluntary provider agency establish procedures and assign responsibility among staff to ensure that all of the following occurs:

- **Assign responsibility for benefit development actions to specific staff trained on benefit development.** The timing of these actions is critical. Staff assigned this area of responsibility must know the benefit program requirements and have the time to handle the associated benefit development issues.

- **Evaluate the individual's potential for benefits.** It is important that the person who handles benefit development or assists individuals with those actions knows the financial history of the individuals he or she is assisting. Information about an individual's history of benefits and the information needed for benefit applications should be gathered in coordination with the person's service coordinator. This information will help identify benefits for which an individual may be eligible and for which an application should be filed.

- **Do protective filings for SSI.** An individual's SSI benefit is effective the month after the SSI application is filed or the month after the first month the individual is eligible for SSI, whichever is later. The filing date is the date that a person contacts the local Social Security Administration office to make an appointment. This initial contact is referred to as the "protective filing date". It is important to be aware of these parameters when developing an SSI benefit for an individual in order to maximize the person's benefit.

- **Apply for Medicaid while SSI is still pending.** File a Medicaid application when the application for SSI is made. This will maximize the retroactive period for Medicaid coverage.

- **Apply for new benefits, report changes, and submit recertifications and renewals in a timely manner.** It is in the best interest of the individuals served that action be taken promptly. This will ensure that benefits are in place at the earliest possible time and are maintained without interruption.

- **Ensure that all mail, information, and other materials regarding benefits are given to the appropriate designated staff and that agency procedures are aligned so this happens.** The person who handles benefit development must be able to react to all determinations regarding benefit eligibility and requests for information in a timely manner.

- **Ensure that designated benefit development staff attend training related to benefit eligibility requirements and processes.** Benefits and Entitlements training, which is offered by OPWDD semi-annually, provides the basic information needed to obtain and maintain Medicaid, SSI, Social Security, Medicare, and Supplemental Nutrition Assistance Program (SNAP) benefits for eligible individuals. This training incorporates advanced topics in these areas as well. Registration for training is done online through the OPWDD website at www.opwdd.ny.gov/opwdd_careers_training/training_opportunities. In addition, Revenue Support Field Offices are available to provide guidance on these and related topics.

- **Maintain all documentation associated with benefits and make copies of the documents.** Documentation of all categorical and financial information related to benefit eligibility is required for benefit applications, recertifications, and renewals. It is important to keep copies of the documents provided to benefit-paying agencies in case the documents are lost. Copies of previously submitted documents also make it easier to know what income, resources, or other eligibility requirements need to be updated at the time of benefit recertifications and renewals.

- **Contest denials and overpayment requests.** If you believe that an application for benefits is appropriate or you disagree with any decision made regarding benefit eligibility or payment, contest or appeal those determinations in order to protect the interests of the individuals.

- **Obtain information needed for future benefit development through regular contact with the individual, family, financial representative, and other sources.** Gather information about the individual, including Social Security number, places of employment, retirement status, health insurance coverage, veteran status, or other information related to benefit eligibility or finances (e.g.,

the individual's bank accounts, life insurance policies, trusts, or burial funds) to develop benefits on the individual's own work or military service record.

- **Plan for future benefits to be developed for the individual when a parent retires, passes away, or begins receiving disability benefits.** At admission, gather and record the information that will be needed to file applications for benefits for the individual based on a parent's work or military service record. The basic information needed includes the parents' full names, dates of birth, Social Security numbers, dates of disability or death, veteran status, and benefit claim numbers.

- **Investigate sources of information about the individual and parents.** Consider phone or in-person contact with the individual, family, financial representative, and other sources of needed information. Contact can take many forms, such as an annual questionnaire sent to the family or other contacts for completion, telephone conversations, discussions when family and friends visit, and speaking directly to the individual.

Your Role as a Benefits Coordinator

Your role as a benefits coordinator is to help individuals with developmental disabilities access benefit and entitlement programs to fund the services they need. This responsibility includes helping individuals and their representatives with the following processes:

- Evaluating the individual's eligibility for benefits and entitlements

- Completing different types of benefit applications

- Filing applications for different types of benefits

- Filing appeals when a benefit application is denied or an existing benefit is terminated

- Maintaining benefits once they are established

Performing these responsibilities requires an understanding of the regulatory systems behind the benefit programs. It is also important for you to understand the support roles played by other individuals and agencies within the benefit development process. After familiarizing yourself with the material contained in the Resource Guide, you should be able to:

- Identify which benefit and entitlement programs are most commonly used to fund an individual's care

- Conduct an investigation to accurately evaluate a person's current or potential eligibility for a number of different types of benefits and entitlements

- Identify the general requirements that an individual must meet in order to qualify for different kinds of benefits, including income and asset levels and other requirements such as citizenship status

- Measure the impact that a person's living arrangement has on his or her benefits

- Identify situations that may prevent an individual from qualifying for or receiving benefits

- Identify strategies that can be used to qualify an individual for benefits if he or she is not currently eligible

- Complete and file different types of benefit applications

- File an appeal when a benefit application is denied or an existing benefit is terminated

- Identify special "expanded" eligibility programs for disabled individuals, which permit some individuals to obtain and maintain Medicaid and/or SSI eligibility even when their income and/or assets are above the normal eligibility levels

- Meet reporting requirements to maintain benefits once they are established

- Use supplemental needs trusts and pre-paid burial contracts to maintain benefit eligibility while preserving the individual's assets

OPWDD offers a wide variety of training opportunities to support you in your role. OPWDD's training catalog can be found on the OPWDD website at www.opwdd.ny.gov/opwdd_careers_training/training_opportunities. Voluntary agencies are encouraged to take advantage of the training programs offered, attend training periodically to refresh and update knowledge, and become familiar with the OPWDD website as it contains a great deal of helpful information and resources.

Service coordinators can be very instrumental in ensuirng that

What is a Benefit Eligibility Investigation?

A benefit eligibility investigation is the process of collecting complete and accurate information on an individual with the goal of assisting the individual to obtain benefits for which he or she is eligible. Receiving benefits will support the services he or she needs.

A benefit eligibility investigation considers not only an individual's current needs but also his or her possible future needs. The goal of the eligibility investigation is to qualify an individual for as broad a range of benefits and services as possible.

Why is a Benefit Eligibility Investigation Important?

Because many factors can affect an individual's eligibility for different benefit programs, it is important to conduct a full benefit eligibility investigation when an individual first applies for services. Collecting complete and accurate information on an individual is critical to benefit development. This is because needs-based benefit programs such as Supplemental Security Income (SSI) and Medicaid have specific income and asset limits for eligibility, and entitlement programs such as Social Security (SSA) and Medicare are based on the work history of an individual, or certain family members.

In some cases, it may be difficult to determine whether an individual may be eligible for certain benefits (e.g., in the case of non-citizen applicants), however, OPWDD encourages benefits personnel to apply for all possible benefits. The benefit-paying agency will make the eligibility determination. If necessary, OPWDD will assist with filing appeals if the determination is unfavorable and there is reason to believe the individual is indeed eligible.

Note: A Benefit Eligibility Investigation Questionnaire has been developed to assist agencies with collecting necessary information (see Benefit Eligibility Questionnaire, page 159 and Instructions for Completing the Benefit Eligibility Questionnaire, page 162).

The Benefit Eligibility Investigation Process

The Benefit Eligibility Investigation involves collecting information about:

- the individual
- the type of coverage the individual needs
- the individual's income
- the individual's assets
- life insurance the individual may hold
- health insurance coverage the individual may have
- the individual's parents and spouse

Each step in the Eligibility Investigation process is described below.

Collecting Information about the Individual

Obtaining information about the individual right from the start is critical for establishing benefits. It is also important to keep in mind that while the individual might not be eligible for a specific type of benefit at the time of application, the individual could become eligible in the future. This means that you should collect as much relevant information about the individual as possible, including:

- Name
- Date and Place of Birth
- Social Security Number
- Veteran Status (if applicable)

- Marital Status
- Spouse's Name (if applicable)
- Date and Place of Marriage/Divorce (if applicable)
- U.S. Citizenship Status
- Alien Registration Number (if not a U.S. citizen)
- Date of Entry to the U.S.
- Port of Entry to the U.S.
- Court Appointed Representation (if applicable) - Legal Guardian, Conservator or Committee, or Trustee

Note: Acceptable forms of documentation are listed beginning on page 11.

Collecting Information to Determine the Type of Coverage the Individual Needs

For individuals who will receive services through OPWDD, it is very important that the correct Medicaid coverage be in place; otherwise, payment for these services may be denied. Filing for full coverage is recommended whenever possible.

Many factors must be considered when applying for benefits for an individual. These include the individual's specific living arrangement (whether or not it is an OPWDD-certified living arrangement), whether the individual is enrolled in the Home and Community Based Services (HCBS) Waiver program, and if the individual has already been documented as disabled. In order to ensure the correct type of coverage, the following questions should be asked:

- Is the individual under the age of 21?
- Does this individual live with his or her parents?
- Is this individual already covered by Medicaid?
- If covered by Medicaid, what is the Client Identification Number (CIN)?
- If not already covered by Medicaid, has a Medicaid application been filed?
- If a Medicaid application has been filed, what was the application date?
- If a Medicaid application has been denied, what was the date and reason for denial?
- Is this individual already enrolled in the Home and Community Based Services (HCBS) Waiver program?
- If not already enrolled in the HCBS Waiver program, has an HCBS Waiver application been filed?
- If an HCBS application has been filed, what was the application date?
- If an HCBS application has been denied, what was the date and reason for denial?

Note: Acceptable forms of documentation are listed beginning on page 11.

Collecting Information about the Individual's Income

Eligibility for certain types of benefits depends not only on an individual's living situation, as indicated above, but also on the amount and type of an individual's income.

Section 2: Benefit Development

Income is defined as any payment received from any source. Income may be received on a recurring basis (e.g., monthly), or as a one-time payment. The categories of income are “Earned” and “Unearned”.

Earned income is received as a result of work activity, including:

- Wages
- Salaries
- Tips
- Commissions
- Self-employment

Unearned income is income paid because of a legal obligation or entitlement rather than for current services performed. Unearned income includes:

- Pensions
- Government benefits such as:
    - Supplemental Security Income
    - Social Security
    - Railroad Retirement
    - Veterans benefits
    - Unemployment Insurance benefits
- Dividends
- Interest
- Insurance compensation
- Support payments

Note: Acceptable forms of documentation are listed beginning on page 11.

Determining Income Eligibility Levels – Questions to Ask

Income eligibility levels change on an annual basis. To assist in determining income eligibility for certain benefits, the following questions should be asked:

- Does the individual receive income from any source, such as:
    - Social Security Disability Insurance (SSDI)
    - Supplemental Security Income (SSI)
    - Veteran’s Administration (VA)
- Is this individual currently working?
- Where does the person reside or expect to reside?

Note: Acceptable forms of documentation are listed beginning on page 11.

Collecting Information about the Individual’s Assets

It is very important to get full disclosure of both an individual’s current and future assets to make sure that the individual is within the asset limits of the specific needs-based

benefit that is being applied for. Needs-based benefits include Supplemental Security Income (SSI), Medicaid, certain VA benefits, and SNAP.

Different benefit programs have different asset limits that may change on an annual basis. Assets should be monitored because benefits will be affected if assets are not within the specific limits for the benefit.

Determining Current Assets – Questions to Ask

In order to obtain information about an individual's current assets, the following questions should be asked:

- Has the individual sold, given away or transferred any cash, real estate, or other asset(s) during the last 60 months? **Note:** This question should be asked only if the individual will be residing in an ICF.
- Has the individual placed any asset(s) into a trust or have any disbursements been made from a trust established for the individual's benefit?
- Does the individual have any bank account(s), credit union account(s), certificates of deposit, annuity, 401(k), other retirement account, stocks, bonds, securities, or interest in real property (including home ownership)?
- Does this individual have a burial fund?
- Does the individual have a pre-need funeral contract, a burial trust, a burial plot or other burial space items?

Note: Acceptable forms of documentation are listed beginning on page 11.

Determining Future Assets – Questions to Ask

There are times when it is anticipated that an individual will receive money at some point in the future. This could affect the individual's needs-based benefits. It is important to obtain as much information as possible regarding any future assets to avoid potential problems with the individual's benefits. If the information is known ahead of time, there are various ways that the assets can be protected for the individual so that he or she remains eligible for benefits. The following question should be asked:

- Does the individual have an interest in, possible interest in, or expect to receive an inheritance, lawsuit settlement, trust fund or other asset?

Collecting Life Insurance Information about the Individual

Having life insurance may affect an individual's benefits. It is therefore necessary to determine whether the individual has life insurance and if so, to monitor policies to ensure that they remain within benefit limits.

Life insurance that has a cash surrender value and is owned by the individual is excluded from countable resources if the total face value of all policies that are owned is $1,500 or less. However, if the total face value of life insurance is more than $1,500, the total cash surrender value (the amount that the insurer will pay upon cancellation of the policy before death or maturity) of the insurance counts as a resource. If specifically

designated as funds set aside for burial, up to $1,500 can be excluded from the individual's resources for that purpose.

Note: Acceptable forms of documentation are listed beginning on page 11.

Collecting Health Insurance Information about the Individual

Because Medicaid is the payer of last resort, it is important for the local Department of Social Services to know about any other health insurance coverage an applicant may have.

The following questions should be asked:

- Does the individual have Medicare?
    - If yes, is it:
        - Medicare Part A (Hospital Insurance)
        - Medicare Part B (Medical Insurance)
        - Medicare Part C (Medicare Advantage Plan)
        - Medicare Part D (Prescription Drug Plan)
- If the individual has Medicare Part A or Part B, what is the effective date and the Medicare claim number?
- If the individual has Medicare Part D or Part C, what is the effective date of coverage, the plan name and number, and the policy number?
- Is the individual covered by any other type of health insurance through an employer or a family policy?
    - If so, what is the effective date of coverage, the policy number, group number, subscriber's name and name and address of the group/employer?

Note: Acceptable forms of documentation are listed beginning on page 11.

Collecting Information about the Individual's Parents and Spouse

Individuals may become entitled to certain benefits based on the work record of a parent or spouse (if applicable). It is important to be aware whether the person's spouse and parents are working, retired, disabled or deceased, and to take timely action to apply for benefits when the status of a relative changes. The following information about the individual's spouse and parents should be obtained to apply for benefits on behalf of the individual:

- Full Name at Birth/Maiden Name
- Date of Birth
- Place of Birth (City, State)
- Social Security Number
- U.S. Citizenship Status
- U.S. Veteran Status (if applicable)
    - Serial Number of VA
    - Claim Number of VA

- If the parent/spouse is already receiving a disability/retirement benefit
    - If so, what is the date of the disability/retirement?
- If the parent/spouse is deceased
    - If so, what was the date and place of death?

Documenting the Information that has been Collected

When applying for benefits, documentation of information collected about the individual and the individual's assets is required. The following is a list of accepted documentation:

Citizenship or Current Immigration Status

This must be provided for any new person applying or any person renewing eligibility whose status has changed in the past 12 months. Any one of the following is acceptable verification:

- U.S. Birth Certificate
- U.S. Passport
- U.S. Baptismal Certificate
- Official U.S. Hospital/Doctor Records
- Certificate of Naturalization (N-550 or N-570)
- Permanent Resident Card (I-551) issued by the Department of Homeland Security (DHS)
- One of the following, issued by the U.S. Citizenship and Immigration Services (USCIS):
    - Arrival/Departure Record (I-94)
    - Voluntary Departure Notice Letter (I-210)
    - Order of Supervision (I-220B)
    - Memorandum of Creation of Record of Lawful Permanent Residence (I-181)
    - Employment Authorization Document (I-766)
    - Notice of Action (I-797)

Residency/Home Address

This must be provided if the individual's address or living arrangement has changed since the last renewal/application. Acceptable verification is as follows:

- ID card with address
- Driver's license issued within past six months
- Letter/lease/rent receipt with home address from landlord
- Property tax records or mortgage statement
- Postmarked envelope, postcard, or magazine label with name and date
- Utility bill (gas, electric, cable), bank statement, or correspondence from a government agency

Income and Assets

Anyone applying for or renewing a needs-based benefit must submit proof of income and assets. Acceptable verification is as follows:

Income

- Earned income from employer – current paycheck/stubs (four consecutive weeks) or letter from employer.
- Self-employment income – current signed income tax return or record of earnings and expenses
- Rental/roomer-boarder income – letter from roomer, boarder, tenant or check stub
- Unemployment benefits – award letter/certificate, benefit check stub, correspondence from NYS Department of Labor
- Private pensions/annuities – statement from pension/annuity
- Social Security benefits – award letter/certificate, benefit check stub, correspondence from Social Security Administration
- Employment-based sick pay/disability income – award letter/certificate, benefit check stub, correspondence from source of income
- Child support/alimony – letter from person providing support, letter from court, child support/alimony check stub
- Worker's Compensation – award letter, check stub
- Veteran's benefits – award letter, benefit check stub, correspondence from Veterans Administration
- Military pay – award letter, check stub
- Interest/dividends/royalties – statement from bank, credit union, or financial institution, letter from broker, letter from agent
- Support from other family members – signed statement or letter from family member
- Income from a trust – photocopy of trust document or a sheet with details about the trust, including the source of the money, the name of the trustee, location of the trust, account number and the value of the trust
- Other income not listed above – signed statement or letter from the person/source providing the income.

Assets

- If the individual sold, given away or transferred any cash, real estate, or other asset(s) during the last 60 months – information about the type of asset, name of the person receiving the bank statements or holding the records
- If the individual has any bank account(s), credit union account(s), certificates of deposit, annuity, 401(k), other retirement account, stocks, bonds, securities, or interest in real property (including home ownership) – description and details of

the asset(s), bank statements, deed or appraisal for real estate, copies of stocks, bonds, or securities

- If the individual has a burial fund, pre-need funeral contract, a burial trust, a burial plot or other non-burial items – a copy of the contract(s)
- If the individual has life insurance – insurance company's name and address, the policy number, the face value of the policy and the name and address of the person holding the policy.
- Private or Employer Based Health Insurance – copy of the insurance policy, premium statement, and insurance card. If the insurance has ended, a termination letter needs to be provided.

Responsibility for Maintaining Individuals' Benefits

In 2012, OPWDD clarified the entities that are primarily responsible for assisting individuals with developing and maintaining their benefits, including filing all applications, recertifications, and meeting all reporting requirements for each benefit for which the person is eligible/entitled.

The person or entity responsible for this depends on the person's living arrangement and other factors. The following should be used as a guide to determine primary responsibility for benefit development/maintenance.

If the individual resides in a certified residential setting:

- Residential agency staff is responsible if the residential agency is or will be Representative Payee for the person's SSI and/or Social Security benefits and Authorized Representative for Medicaid and/or SNAP benefits.
- The Medicaid Service Coordinator is responsible for assisting the person if the person is capable of handling his or her benefits.

If the individual resides in the community, the Medicaid Service Coordinator is responsible for assisting the person as needed. If the person has a parent, other family member or friend serving as Representative Payee, the Medicaid Service Coordinator should provide assistance to the Representative Payee if requested to do so.

The above clarification does not remove any of the responsibilities placed on providers under the Liability for Services regulations to ensure the individuals they serve obtain and maintain the coverage necessary to pay for the services they receive.

Liability for Services

Liability for Services Regulations

The Office For People With Developmental Disabilities (OPWDD) has promulgated regulations concerning the liability for services for specified OPWDD Medicaid and Home and Community Based Services (HCBS) Waiver funded services, located in 14 NYCRR 635.12. Under these regulations, individuals with developmental disabilities who wish to receive a specified OPWDD Medicaid funded service to file and be approved for "Full Medicaid Coverage". "Full Medicaid Coverage" is defined as the minimum level of coverage necessary under the Medicaid program to pay for the services being requested or received. Additionally, if an individual wants to receive an OPWDD HCBS Waiver service, the individual must take all necessary steps to enroll in the HCBS Waiver.

The regulations impose different requirements depending on whether a service is 'preexisting' or 'other than preexisting'. **Preexisting** services are those that an individual had been receiving on a regular basis at the time the regulations were implemented for the specific services. **Other than preexisting** services are those that commenced on or after the date the regulations went into effect for the specific service. The implementation dates were:

February 15, 2009 for ICF/DD facilities; residential habilitation delivered in IRAs, CRs, and family care; and day habilitation

March 15, 2010 for Medicaid Service Coordination, Day Treatment Services, At-Home Residential Habilitation, Prevocational Services, Supported Employment Services (SEMP), Respite Services and Blended and Comprehensive Services

In the future, as new services are implemented within the OPWDD delivery system, these services may also be subject to the liability for services regulations.

To access full text of the regulations, visit OPWDD's website at www.opwdd.ny.gov/regulations_guidance/opwdd_regulations. Additional materials related to the Liability for Services regulations and their implementation are also accessible at www.opwdd.ny.gov/opwdd_resources/benefits_information/liability_for services/overview.

Service Recipient Responsibilities

In order for service providers to secure Medicaid payment for services, individuals requesting covered services (see above) and their families or advocates must take all measures necessary to facilitate benefit eligibility by fully cooperating with service providers, OPWDD, local Social Services districts, and other benefit-paying agencies in the benefit development and HCBS Waiver enrollment processes. This includes full

disclosure of financial information and any other information necessary to establish eligibility.

Individuals who wish to receive these services but do not wish to apply for benefits will have to arrange to pay the service provider directly. Service providers are not obligated to begin serving individuals who refuse to apply for benefits or disclose financial information necessary to determine the ability to pay.

If an individual has made every attempt to apply for Medicaid and/or Waiver enrollment but cannot meet eligibility guidelines, the service provider may request OPWDD approval of a fee waiver or fee reduction. For more guidance, please see Liability for OPWDD Medicaid and Home and Community Based Waiver Services (Guidance Document), available at www.opwdd.ny.gov. This document provides a thorough overview of the regulations and the responsibilities of both service providers and service recipients.

Service Provider Responsibilities

In order to be in compliance with the regulations and, in some cases, continue to receive state funding, a service provider must fully comply with all of the requirements of the regulations. The key requirements include the following:

- Calculate charges for the costs of services based on the individual's living arrangement, income and resources
- Issue the liability notice(s) (OPWDD LIAB 05-09) including the fee schedule to the individual and/or liable parties for all services covered by the regulations
- Issue the Billing Account Notice (OPWDD LIAB 03) to notify the individual and/or liable parties that billing will commence
- Bill and collect the full cost of services for services covered by the regulations
- Complete the fee waiver or fee reduction request form (OPWDD LIAB 04) when special circumstances merit its use
- Complete the Request to Assign Unpaid Amounts to OPWDD form, after all reasonable collection attempts have been unsuccessful (only applicable if provider has been receiving payments from OPWDD for the person's services for the period during which the unpaid amounts have accrued)

Detailed information on all service recipient and service provider responsibilities and corresponding forms for service provider use, can be found on the OPWDD website under Resources/Benefits Information at www.opwdd.ny.gov.

Getting Assistance from OPWDD

OPWDD's local Revenue Support Field Offices (RSFOs) are available to assist service providers, individuals seeking services, and their families and advocates as they work to establish eligibility for Medicaid and other benefits. The RSFO can also provide guidance in appealing denials. If the Medicaid application of an individual seeking services is denied, the individual and/or the service provider must present the denial notice to the local OPWDD Revenue Support Field Office (RSFO) for review and help with an appeal, if appropriate.

A complete listing of the RSFOs and their service areas can be found in the Additional Resources section (Revenue Support Field Offices Service Areas, page 155, and Revenue Support Field Offices, page 156).

The responsible DDSOO/DDRO will assist service providers in establishing HCBS Waiver enrollment.

Timely Application Submission

OPWDD does not guarantee state funding for services provided before Medicaid/Waiver eligibility is established. It is, therefore, in the service provider's best interest to ensure that Medicaid and HCBS Waiver applications are submitted in a timely manner. For individuals who qualify for Medicaid and, as necessary, the HCBS Waiver, the service provider must submit its claim for payment for services directly to eMedNY, retroactive to the date of Medicaid eligibility/HCBS Waiver enrollment. Providers must defer online entry of services and submissions of claims through the Web Applications for SEMP, Respite and OPTS services until all eligibility factors for an individual have been met. Payments made by OPWDD are subject to review and, if the individual does not qualify for Medicaid and the HCBS Waiver, OPWDD may recover any payments made to the provider.

If the RSFO concurs with a local DSS determination that an individual is not eligible for Medicaid and/or the DDSOO/DDRO determines that the individual is not HCBS Waiver eligible, the matter will be referred to the appropriate DDSOO, which will determine if services are needed and, if applicable, the level of services the individual should receive.

Eligibility for OPWDD Services

In order to receive services in most OPWDD funded programs, an individual must be determined by OPWDD to have a developmental disability and to be eligible for services. Authorized DDSOO staff must determine an individual's eligibility for OPWDD services, regardless of what agency, provider or practitioner will render the services. A determination of developmental disability does not mean the person is eligible for all OPWDD funded services. Some OPWDD funded programs such as Intermediate Care Facilities (ICFs) and Home and Community Based Services (HCBS) Waiver programs have additional eligibility criteria.

Eligibility Determination Request

An OPWDD Transmittal Form, including the name of the individual, the name of the individual's representative and relevant contact information, and documentation of the individual's developmental disability must accompany requests submitted to the DDSOO for eligibility determinations.

1st Step Review

During a 1st Step Review, DDSOO staff review the request for completeness and share the information with other staff designated by the Director as necessary. The DDSOO then notifies the individual in writing that eligibility or provisional eligibility has been determined, that the request is incomplete and requires additional documentation, or that the request has been forwarded for a 2nd Step Review.

2nd Step Review

The 2nd Step Review is conducted by DDSOO clinicians designated by the DDSOO Director. If additional medical information, psychological test results, or historical documentation is required, the individual is notified in writing of the type of information needed and the date by which it must be submitted to the DDSOO. Following this step, the DDSOO provides the individual with written notification of its determination. If the individual is found ineligible for OPWDD services because he or she does not have a developmental disability, the letter will offer the individual and his or her representative the opportunity to meet with DDSOO staff to discuss the determination, the opportunity to request a 3rd Step Review, and the opportunity to request a Medicaid Fair Hearing if applicable.

Note: A Notice of Decision informing the individual of his or her right to request a Medicaid Fair Hearing is sent only when the Transmittal Form indicates that the individual is interested in receiving Medicaid funded OPWDD services. Otherwise, no fair hearing is offered and the decision of the DDSOO is final.

3rd Step Review

The individual may choose any or all of the above options if determined ineligible at the 2nd Step Review. If a fair hearing is requested, a 3rd Step Review will automatically be conducted. The 3rd Step Review is conducted by Eligibility Determination Committees located at the Service Delivery and Integrated Solutions for New York City residents, or at the Upstate Regional Office in Albany for all other New York residents. Committee members include licensed practitioners not directly involved in the determinations made at the 1st and 2nd Step Review process. The Committees review the eligibility request and any additional documentation provided by or on behalf of the individual. The Committee forwards its recommendations to the DDSOO 2nd Step Review coordinator. The DDSOO Director or designated staff person considers the 3rd Step recommendations and informs the person of any change in the DDSOO's determination. 3rd Step reviews will be made prior to any fair hearing date.

Medicaid

Medicaid is a health insurance program for people with low income. It provides coverage for children; people who are aged (65 or older), blind, and/or disabled; and other people who are eligible to receive medical assistance. In New York State, under an agreement between SSA and the New York State Department of Health (DOH), SSI beneficiaries are also eligible for Medicaid.

The Medicaid program is administered by the New York State Department of Health through the local Departments of Social Services (LDSS). The timing of benefit-related actions, including applications and change reporting, is critical to an agency's operations because SSI eligibility is not retroactive and maximum retroactivity for Medicaid is three months.

For most individuals who live in state-operated residential programs and certain individuals in certain voluntary agency residential programs, Medicaid is administered by OPWDD as Medicaid District 98 through the Revenue Support Field Offices (RSFOs). The district of Medicaid responsibility for these individuals depends upon their living arrangements and sometimes on the individuals' Chapter 621 eligibility.

Chapter 621

In order to be Chapter 621 eligible, an individual must have at least five years of continuous *inpatient status* service provided by a state facility (i.e., developmental center or psychiatric center). A qualifying stay must include a continuous five-year period since June 29, 1969. Inpatient status is defined as residential status without discharge or release from the facility/facilities for any period of 90 days or longer. Time in family care is not considered inpatient unless the person is on legal status. Generally, a person is on "legal status" when he or she is placed in family care from an inpatient residence and his or her inpatient legal status is not terminated. Time spent in a Private Certified School for the Mentally Retarded or an Intermediate Care Facility does not count toward the five-year continuous inpatient service requirement.

District of Responsibility

The following chart shows when Medicaid is the responsibility of OPWDD District 98 and when it is the responsibility of the LDSS, based on living arrangement and Chapter 621 status:

	Responsible Medicaid District		
	Living Arrangement	**Chapter 621**	**Non-Chapter 621**
	At Home	LDSS	LDSS
State-Operated	Developmental Center (DC)	OPWDD (98)	OPWDD (98)
	Family Care (SOFC)	OPWDD (98)	OPWDD (98)
	Intermediate Care Facility (SOICF)	OPWDD (98)	LDSS
	Individualized Residential Alternative (SOIRA)	OPWDD (98)	LDSS
Voluntary-Operated	Agency Sponsored Family Care (ASFC)	OPWDD (98)	OPWDD (98)
	Intermediate Care Facility (VOICF)	OPWDD (98)	LDSS
	Individualized Residential Alternative (VOIRA) converted from ICF (VOICF)	OPWDD (98)	LDSS
	Individualized Residential Alternative (VOIRA) not converted from ICF (VOICF)	LDSS	LDSS
	Community Residence (VOCR)	LDSS	LDSS

Individuals applying for SSI should also apply for Medicaid because:

- SSI applications can take up to six months to be processed
- Medicaid can be retroactive for three months
- Individuals eligible for Medicaid benefits may not be eligible for SSI

Medicaid and SSI are available to United States citizens and qualified non-citizens (see Identity and Citizenship or Immigration Status for the Medical Assistance Program, page 169 and Documentation Guide – Citizenship and Immigrant Eligibility for Health Coverage in New York State, page 171). OPWDD-funded programs are only available to legal residents of New York State.

Types of Medicaid Coverage

It is important that you apply for the appropriate coverage and include the necessary documentation to ensure that individuals are covered for the services they require.

Individuals Residing in Institutional Settings (ICF, NF, DC SRU)

Full coverage (Medicaid Coverage Code 01) is necessary for individuals receiving OPWDD services in institutional settings and requires documentation of resources for up to the past 60 months. Institutional settings include Intensive Care Facilities (ICF), Nursing Facilities (NF), Developmental Centers (DC), and Small Residential Units (SRU).

Individuals Residing in Community Settings (IRA, FC, CR, At Home)

Individuals residing in the community should apply for *Community Coverage with Community-Based Long Term Care (Medicaid Coverage Code 19 or 21).* This covers all Medicaid covered care and services, including adult day health care, Personal Care, private duty nursing, the assisted living program, OPWDD HCBS Waiver services, and Medicaid Service Coordination. For this type of coverage, individuals must document the value of their current resources at initial application. This coverage type does not cover Nursing Facility long-term care services and equivalents or Intermediate Care Facilities. Individuals with excess countable income will have a spenddown and the Medicaid will be set up with Medicaid coverage code 21.

Note: *Community Coverage without Long Term Care (Medicaid Coverage Code 20 or 22)* does not cover Intermediate Care Facilities or OPWDD HCBS Waiver services and is therefore not appropriate for individuals applying for OPWDD services. Medicaid coverage code 22 indicates the individual has a spenddown.

If the Medicaid district gives an OPWDD HCBS Waiver enrolled individual Community Coverage without Long Term Care (Medicaid Coverage Code 20 or 22), the individual or his or her representative **must** request that the coverage type be changed to Community Coverage with Community-Based Long Term Care (Medicaid Coverage Code 19 or 21).

How to Apply for Medicaid

Determining an Individual's Medicaid Status

Refer to Examples and Flow Charts at the end of this section concerning individuals without Medicaid coverage and individuals who already have Medicaid. These charts are provided to assist benefit development personnel in determining the appropriate actions to take with regard to an individual's Medicaid status.

Medicaid and the Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (ACA) provides for expanded Medicaid coverage for certain Medicaid categories and introduced a new budgeting methodology for individuals in these categories, called MAGI (modified adjusted gross income) budgeting, which uses IRS guidelines to calculate countable income. MAGI budgeting does not apply to most individuals served by OPWDD and its service providers; however, it is important to understand when MAGI budgeting may come into play.

Health Benefit Exchange

In accordance with the requirements of the ACA, New York State has established a virtual marketplace where New York state residents can shop for health insurance plans, find out whether they are eligible for Medicaid, and determine eligibility for a subsidy, called an advance premium tax credit (APTC), to offset the cost of purchasing insurance through the marketplace. APTCs are applied automatically for qualifying individuals when they purchase a plan, resulting in a lower monthly premium.

Section 4: Medicaid

New York's health benefit exchange is called New York State of Health (NYSOH), and can be found at: https://nystateofhealth.ny.gov/. The NYSOH Medicaid application is done online. Individuals can get assistance with the process by calling 1-855-355-5777. Assistance is also available from Certified Application Counselors (CACs), In-Person Assistors (IPAs) and Navigators.

IPAs, Navigators and CACs are trained and certified to assist individuals and small businesses with the Marketplace. IPAs and Navigators are available in convenient community-based locations in every county, while CACs may work for entities such as hospitals, clinics, providers or health plans.

To find assistance near you, use the search function available at: https://nystateofhealth.ny.gov/agent/hx_brokerSearch?fromPage=INDIVIDUAL.

NYSOH or LDSS?

Individuals who want OPWDD services must have a disability determination completed in order to qualify for Medicaid and will need to continue to apply for and obtain their Medicaid coverage through their Local Department of Social Services (LDSS). If individuals without a disability determination who wish to receive OPWDD services apply for Medicaid through NYSOH, they should be referred to the LDSS to apply. **Individuals served by OPWDD or its voluntary providers should only apply for Medicaid through NYSOH if they only want OPWDD Medicaid Service Coordination and are not required to/do not plan to enroll in the OPWDD HCBS Waiver** (see Liability for Services, beginning on page 14; and Home and Community Based Services Waiver, beginning on page 49.

An exception to this may occur if individuals served by OPWDD are also Medicare-enrolled "caretaker relatives" and qualify on that basis, as well as on their income, for Medicaid. Since caretaker relatives have Medicare, they have the necessary disability determination and can have OPWDD HCBS Waiver services paid by Medicaid with the coverage they receive through NYSOH. These cases will need to be looked at on a case-by-case basis to determine whether the OPWDD services the person wants can be provided with the type of Medicaid coverage they qualify for through NYSOH. If the specific service is in the state plan (e.g., Medicaid Service Coordination), NYSOH Medicaid coverage may be sufficient, but if they want to receive HCBS Waiver services, which are specific to OPWDD (e.g., Community Habilitation), NYSOH Medicaid coverage may not be sufficient and they would need to apply through LDSS.

Individuals in receipt of Social Security Disability Insurance (SSDI) payments or who are enrolled in Medicare have already had a disability determination completed. In these cases, LDSS adopts the determination for Medicaid purposes; however, individuals receiving SSDI or Medicare still need to apply for Medicaid through LDSS if they are seeking OPWDD services.

Income and Resources

For Medicaid eligibility determinations through LDSS, all income, both earned and unearned, is reviewed to determine if it is available and countable. Certain types of income or a portion of certain income may be disregarded in determining an individual's countable income. Countable income is compared to the appropriate income level in determining Medicaid eligibility. The appropriate income level is determined based on a person's particular residential situation. Income in excess of the appropriate income level is considered available to meet the cost of medical care.

Resources are reviewed to determine their availability and value as of the first day of each month for which an individual is seeking or receiving Medicaid coverage. The treatment of resources varies by type of resource. Not all available resources are counted and certain resources are disregarded in determining the individual's countable resources. Countable resources are compared to the applicable resource level in determining Medicaid eligibility. The Medicaid resource level is $14,550, effective January 1, 2014.

If an individual is married, his or her spouse's income and resources may also be considered. If the individual is under 18 years old and is not enrolled in the OPWDD HCBS Waiver, his or her parents' income and resources will also be considered.

Note: A retirement fund owned by an individual is a countable resource only if the individual is not entitled to periodic payments but is allowed to withdraw any of the funds. The value of the resource is the amount of money that the individual can currently withdraw. If there is a penalty for early withdrawal, the value of the resource is the amount available after the penalty deduction. Any income taxes due are not deductible in determining the value of the resources. If the individual is in receipt of, or has elected to receive, periodic payments, the retirement fund is not a countable resource. Instead, the periodic payments are considered income in the month of receipt.

Lump Sum, Windfall, and Retroactive Payments

Lump sum benefits are deferred or delayed payments, such as benefit awards, bonuses, and retroactive pay increases. Windfalls are one-time only payments, such as personal injury awards or inheritances. All lump sum benefits and windfalls must be reviewed to determine if they are considered available to the individual.

For SSI-related individuals (i.e., age 65 or older, blind, or disabled), lump sum payments must be evaluated to determine if they are available and countable. Lump sum payments as a result of employment, such as retroactive pay increases, are considered earned income. Lump sum payments, such as benefit awards from Social Security are unearned income. Countable lump sum payments are considered income in the month received. Amounts retained beyond the month of receipt are considered available resources.

For SSI-related individuals, windfall payments are considered countable income in the month received. Amounts retained beyond the month of receipt are considered available resources.

Retroactive Supplemental Security Income (SSI) awards are disregarded as income in the month received and disregarded as a resource for the nine months following the month of receipt.

Retroactive Social Security awards are considered unearned income in the month received and disregarded as a resource for the nine months following the month of receipt. Local districts are required to adjust an ICF resident's Net Available Monthly Income (NAMI) following receipt of a retroactive Social Security award (or other payment that is considered income in the month received) to reconcile an overpayment based on the person's change in income. However, retroactive Social Security benefits paid for months that the individual received SSI benefits are not counted as income.

Note: Lump sum payments or windfall payments received by SSI-related individuals under the age of 65 are considered income in the month received; any portion of a lump sum payment or windfall payment retained after the month of receipt is considered a resource. Assets of a disabled person under age 65 will be disregarded if placed in an exception trust. See the Resource Management section, beginning on page 146, for a more thorough discussion of exception trusts.

Filing the Application through the Local Department of Social Services

If the person does not receive SSI, the individual or the individual's authorized representative must file an application with the responsible Medicaid district (refer to the chart on page 18) to obtain Medicaid. If an individual is applying for SSI, it is recommended that the individual apply for Medicaid at the same time since Medicaid can be retroactive for 3 months if the individual is eligible. SSI is not retroactive.

Note: When SSI recipients apply for SSI, their Medicaid case should be automatically opened in the appropriate district. If Medicaid is not opened, the individual or his or her representative should bring the individual's SSI award letter to the LDSS so that Medicaid can be opened.

All Medicaid applicants applying through the local district must use the Access NY Health Care application (DOH-4220) (see page 202). In addition, individuals requesting HCBS Waiver services and individuals requiring care in an Intermediate Care Facility (ICF) or Developmental Center (DC) must also file the Access NY Health Care Supplement A (DOH-4495A) (see page 211). In addition, individuals seeking HCBS Waiver services must provide documentation of their *current* resources. For ICF/DC care, individuals must provide documentation of their resources for up to 60 months prior to the date of application.

To assist individuals in completing the Access NY application and providing the necessary documentation, the following materials are available:

- Documents Needed when you Apply for Health Insurance (DOH-4220B)
- Access NY Health Care application instructions (DOH-4220-I)

The document checklist and instructions for completing the Access NY application can be found beginning on pages 199 and 217, respectively.

Face-to-Face Interviews

Individuals are not required to appear for face-to-face interviews when applying for Medicaid, however, individuals may ask for application assistance from the appropriate LDSS or the local RSFO. See the listing of Local Departments of Social Services, beginning on page 185 or, for District 98 individuals, see Revenue Support Field Offices, beginning on page 156, for contact information.

Acceptance Process

After an application is submitted, the Medicaid district will determine whether the individual is eligible and will send a letter notifying the individual of acceptance or denial within 45 days of the date of the application. If a disability determination is required, it may take up to 90 days to determine eligibility.

Medicaid Eligibility

Medicaid eligibility is based on both financial and non-financial factors. Because Medicaid is a needs-based program, individuals must meet certain income and resource requirements in order to qualify. There are a number of Medicaid categories with unique requirements and financial eligibility factors (see Medicaid Categories, page 183, and 2014 Eligibility for Medicaid, page 184). The primary categories used for individuals served by OPWDD and its provider agencies are:

- **SSI Recipients:** People who receive SSI and are automatically eligible for Medicaid (see the section on SSI for eligibility criteria)

- **SSI-Related:** People who do not receive SSI but are blind, disabled, or 65 years of age or older and meet Medicaid eligibility standards

- **MBI-WPD:** People who work may be eligible through the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD), allowing them to earn income above the limits for SSI recipient or SSI-related categories

Note: There are standard requirements for Medicaid eligibility (see Medicaid Categories, page 183, and 2014 Eligibility for Medicaid, page 184); however, programs exist for individuals whose income or resources exceed the standard levels. It is expected that individuals will apply for Medicaid even if they do not appear to qualify based on their income or resources, as there are a number of ways for an individual to achieve eligibility as discussed below.

Expanded Eligibility Programs

A number of programs exist for individuals whose income and/or assets exceed the standard eligibility levels but who meet certain other criteria. These programs include:

- Medicaid Spenddown (Excess Income Program)
- Medicaid Buy-In For Working People With Disabilities (MBI-WPD)

Medicaid Excess Income Program (Spenddown or Surplus Income Program)

SSI-related individuals (i.e., age 65 or older, blind, or disabled) who are not eligible for Medicaid coverage because their income is higher than the Medicaid level for their particular residential situation must be given the opportunity to obtain coverage with a spenddown.

To qualify, the individual's medical expenses must be equal to or greater than the amount of his or her "excess income". Excess income refers to the portion of countable total monthly income that is over and above the Medicaid level for the person's living situation. To participate, the individual pays the amount of his or her excess income (or incurs expenses equal to or greater than the amount of his or her excess income), toward the cost of medical expenses each month. This effectively reduces income to the Medicaid level and Medicaid pays for remaining covered medical expenses during that month.

Upon notification that an excess income situation exists, the individual, his or her representative, or the individual's service coordinator must develop a plan to ensure that the individual's monthly spenddown requirement is met and that the LDSS is notified as early as possible in the month. It may be necessary to follow up with the LDSS to ensure that coverage is in effect.

Medical expenses that may be applied toward the spenddown include:

- Any OPWDD or voluntary agency-provided Medicaid billable service for which there is a rate or fee in place, e.g., service coordination, waiver, clinic, and day treatment services (waiver services can only be used for spenddown purposes if the individual is enrolled in the HCBS Waiver)

- Medical or dental expenses or payments made to physicians, therapists, nurses, personal care attendants, and home health aides (as required by a physician)

- Reasonable transportation expenses to obtain necessary medical services

- Prescription drug bills

- Payments made toward surgical supplies, medical equipment, prosthetic devices, hearing aids, and eye glasses (as ordered by a doctor)

- Expenses for chiropractic services (and other non-covered medical services)

- Costs of some over-the-counter drugs and medical supplies such as bandages and dressings if ordered by a doctor and/or that are medically necessary

Individuals have the choice of meeting the spenddown in one of two ways:

- **By incurring medical expenses equal to or greater than the excess income:** An individual can become eligible for Medicaid for outpatient care and services in any month he or she has medical bills that equal or exceed the monthly spenddown amount and submits those bills to the Medicaid district office. When a person submits paid or unpaid medical bills equal to or greater than the excess monthly income, he or she may receive Medicaid coverage for all other eligible outpatient services for that month. In this case, outpatient coverage is provided on a month-to-month basis.

  An individual can become eligible for full Medicaid coverage (inpatient and outpatient) for six months if he or she incurs or pays medical bills equal to the total of six months of monthly excess income and presents those bills to the Medicaid district office.

- **By pre-paying excess income directly to the Medicaid district:** This is called the Pay-In Program. To obtain coverage, the individual pre-pays his or her monthly excess income to the Medicaid district. The individual may elect to pre-pay for periods of one to six months. For pay-in periods of less than six months, outpatient coverage is authorized for a particular month only after the payment is made for the month. If the individual pays the total excess income for a six-month period, full Medicaid coverage is provided for that period.

  Medical expenses must be incurred in order to have them applied toward a spenddown. The individual may provide a combination of bills (paid or unpaid) to the Medicaid district to have the appropriate bills applied against his or her excess income. Expenses incurred for necessary medical and remedial services recognized under state law, whether covered by Medicaid or not, may be deducted from income.

To establish an effective spenddown arrangement for an individual, the following should be considered:

- Whether the individual has sufficient medical expenses that may be applied toward the spenddown and whether those services are provided by OPWDD, a voluntary agency, and/or other provider

- To whom payment of the spenddown must be made (i.e., to one or more service providers, OPWDD, and/or the local Medicaid district)

- Whether to fulfill the spenddown requirement by using the spenddown program or by participating in the Pay-In Program (see above)

Budgeting Income

Local social services districts use a budgeting process to determine the countable value of an applicant's income. Budgeting differs based on the individual's Medicaid category. The following budgeting methodology applies to individuals who have Medicaid through the SSI-Related category (i.e., individuals who are age 65 or older, blind, or have a disability) and the Medicaid Buy-In Program for Working People with Disabilities. Note that while the budgeting methodology is the same, individuals who participate in the Medicaid Buy-In Program for Working People with Disabilities cannot spend down their excess income to qualify for the program.

1. Calculate the individual's countable unearned income:

    a. Deduct the $20.00 general income disregard from the individual's unearned income. If the unearned income is less than $20.00, the remainder of the disregard is subtracted as the first deduction from earned income (see Step 2.a. below). This general income disregard is not applicable for a person in an ICF/DD or nursing home.

    b. Deduct health insurance premiums if paid from unearned income.

    c. If the health insurance premium is greater than the amount of unearned income remaining after Step 1, the balance of the health insurance premium amount is subtracted from earned income. Refer to Step 2.f.

2. Calculate the individual's countable earned income:

    a. If the full $20.00 general income disregard could not be applied to the individual's unearned income (Step 1.a.), deduct the balance of the $20.00 general income disregard from the total gross monthly earnings. Remember, this disregard is not applicable for a person in an ICF/DD or nursing home.

    b. Subtract the $65.00 earned income exclusion from the remaining total gross monthly earnings.

    c. If the individual has any impairment-related work expenses (IRWE), deduct those after the $65.00.

    d. Deduct one-half of any remaining earned income also as an earned income exclusion.

    e. If the individual has blind work expenses (BWE), deduct those after the one-half deduction.

    f. If the individual has an approved Plan to Achieve Self Support (PASS), deduct the amount placed in the PASS account.

    g. If the individual has health insurance premiums that were not fully deducted from unearned income, deduct those.

3. Add the countable unearned income and countable earned income to calculate the individual's total countable monthly income.

4. Compare the individual's total countable monthly income to the applicable Medicaid income level (see chart on page 158).

5. For an SSI-related individual, the amount in excess of the Medicaid income level is the monthly spenddown amount. If an SSI-related individual has earned income from working, he or she may want to explore eligibility for the Medicaid Buy-In for Working People with Disabilities, which allows individuals to keep Medicaid coverage at higher income levels.

Local districts use a six-month accounting period to compute an individual's excess income. During this period, the person must be determined provisionally eligible for Medicaid. Coverage may be authorized for one to six months of this period. In months when the individual's medical expenses do not meet or exceed the spenddown amount, he or she remains provisionally eligible for Medicaid, but coverage is not authorized.

Medicaid Spenddown - Example 1

Maria is a single woman with a disability who lives alone. She receives a monthly Social Security benefit of $869.00 and does not work. She applies for Medicaid coverage for April 2014. The local district reviews her Medicaid application, calculates her income, and applies the following deductions:

Unearned Income	
SSDI	$ 869.00
General income disregard	- 20.00
Countable unearned income	**$ 849.00**
Earned Income	
Gross monthly earnings	$ 0.00
Countable earned income	**$ 0.00**
Total Countable Monthly Income	
Countable unearned income	$ 849.00
Countable earned income	+ 0.00
Total countable monthly income	**$ 849.00**

After all deductions have been applied, the local district compares the calculated total countable monthly income of $849.00 to the Medicaid income level of $809.00. Maria's excess income amount (spenddown) is $46.00:

Total countable monthly Income	$ 849.00
Less applicable Medicaid income level	- 809.00
Excess income (spenddown)	**$ 40.00**

Maria has incurred medical expenses in the amount of $160.00 as follows:

- An unpaid bill for dental services provided the previous month for $150.00.
- A paid pharmacy bill for $10.00.

Maria presents those bills to the Medicaid district.

Maria is eligible for Medicaid coverage for April, May, June and July ($40.00 spenddown per month x 4 months = $160.00 in incurred medical expenses).

Medicaid Spenddown - Example 2

Bill is 70 years old and lives in an upstate VOIRA. He receives a monthly Social Security check of $1,275.00 and earns $350.00 per month. Bill was enrolled in the HCBS Waiver effective February 2014 because he had previously met his spenddown and had Medicaid coverage for February and March. He requested Medicaid coverage for April. The local district reviewed Bill's income and applied the following deductions:

Unearned Income	
SSDI	$ 1,275.00
General income disregard	- 20.00
Countable unearned income	$ 1,255.00
Earned Income	
Gross monthly earnings	$ 350.00
Less the first $65 (earned income exclusion)	- 65.00
	$ 285.00
One-half the remainder (earned income exclusion)	÷ 2
Countable earned income	**$ 142.50**
Total Countable Monthly Income	
Countable unearned income	$ 1,255.00
Plus countable earned income	+ 142.50
Total countable monthly income	$ 1,397.50
Less applicable Medicaid Income Level (Upstate VOIRA)	- 1,126.00
Excess income (spenddown)	**$ 271.50**

After all deductions have been applied, the local district compares $1,397.50 to $1,126.00, the Medicaid level for an upstate VOIRA (see chart on page 158). Bill's excess income amount (spenddown) is $271.50.

For Bill to gain Medicaid eligibility for April, he must incur expenses of $271.50 or more for medical services he receives, such as IRA Residential Habilitation and Medicaid Service Coordination. Bill must present the bills or statements of incurred expenses to the Medicaid district or he can pay $271.50 directly to Medicaid.

If Bill were to move to a VOIRA in NYC or Nassau, Suffolk, Westchester or Rockland counties, his excess income amount would be based on the Medicaid level for a

downstate VOIRA, which is $1,156.00 (see chart on page 158). Thus, if Bill lived in a downstate VOIRA and received the same monthly income, his spenddown would be $241.50.

Note: If Bill were under 65 years old, the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) would be an option for him and would allow him to avoid paying a spenddown.

Medicaid Buy-In for Working People with Disabilities (MBI-WPD)

The MBI-WPD program is designed to encourage people with disabilities to start working, return to work, or increase their work efforts by ensuring that eligible working people with disabilities get Medicaid coverage for the services they need and have access to a wide array of health services, including services that are not covered by most commercial health insurance policies. Upon initial application for Medicaid, working individuals will receive an explanation of the MBI-WPD program from his or her responsible LDSS to help them make an informed decision about participating in the MBI-WPD program. Similarly, individuals who have started working since their last renewal will receive an explanation of the MBI-WPD program at recertification. See Explanation of the Medicaid Buy-In Program for Working People with Disabilities, page 196. **Note:** The Explanation of the Medicaid Buy-In Program for Working People with Disabilities is used to inform individuals about the program; however, this document has not been updated by the originating agency to reflect current income and resource limits. Please refer to http://www.health.ny.gov/health_care/medicaid/program/buy_in/ for current information.

A Medicaid applicant may be eligible for the MBI-WPD program if he or she is between the ages of 16 and 65, working (and paying applicable taxes), does not reside in an ICF/DD or DC, and meets the Social Security Administration's definition of disabled. A disability determination may be required if one has not previously been completed. In addition to these eligibility requirements, an individual's income and resources must be within the program limits.

Under the MBI-WPD program, individuals may earn up to $59,388 per year (up to $79,692 for a couple) – up to $2,432 in countable income per month for an individual (up to $3,278 for a couple). These amounts may change annually when the Federal Poverty Levels are announced. Current information can be found at http://www.health.ny.gov/health_care/medicaid/program/buy_in/.

Determining eligibility for this program is done through a budgeting process whereby general and earned income disregards are applied to the individual's gross monthly income and the net amount is considered the individual's monthly "countable" income. If the monthly countable income is within the Medicaid MBI-WPD limits, the individual is eligible for Medicaid through the MBI-WPD program.

Disregards are portions of income (both earned and unearned) that are "disregarded" or excluded from an individual's income for the purposes of determining Medicaid

eligibility. Specifically, the first $20.00 of unearned income is disregarded and is referred to as a general income disregard. If an individual has no unearned income or has unearned income of less than $20.00 per month, the general income disregard or a portion of it is applied to his or her earned income. In addition, a $65.00 disregard is applied to earned income (for a total of $85.00 in income disregards). Finally, one-half of the remaining earned income is excluded or disregarded, to obtain the individual's monthly net income. This amount is considered "countable" for determining Medicaid eligibility.

Resources are reviewed to determine their availability and value as of the first day of each month for which an individual is seeking or receiving Medicaid coverage. The treatment of resources varies by type of resource. Not all available resources are counted and certain resources are disregarded in determining the individual's countable resources. Countable resources are compared to the applicable resource level in determining Medicaid eligibility. The MBI-WPD resource level is $20,000 for an individual (up to $30,000 for a couple both participating in MBI-WPD) as of January 1, 2014.

There is currently a moratorium on premium collection for Medicaid coverage through MBI-WPD, but eventually, the Department of Health will institute a premium that MBI-WPD participants with countable income between 150% and 250% of the Federal Poverty Level (FPL) will have to pay. If an individual has countable income above 250% of the FPL, he or she is not eligible for MBI-WPD.

If an individual has health insurance coverage through his or her employer, he or she should discuss this with the LDSS or the local RSFO before applying for MBI-WPD coverage. Medicaid may cover the cost of the health insurance premium for the individual. If the person has family coverage, the individual should be aware that family coverage is not provided through MBI-WPD. Coverage for the individual's spouse and children may be available through NYSOH, the New York state healthcare exchange at: https://nystateofhealth.ny.gov/.

Individuals uncertain about whether or not they should apply for MBI-WPD coverage instead of qualifying in the SSI-related category with a spenddown should contact their local Medicaid district or RSFO before applying. Individuals in receipt of SSI are not eligible for MBI-WPD because they already have full Medicaid coverage.

Note: Examples at the end of this section (beginning on page 41), illustrate the budgeting method used to determine eligibility for the MBI-WPD program.

MBI-WPD Grace Period Requests

A person participating in MBI-WPD who stops working temporarily may be granted a grace period for continued participation in the program, depending on the reason he or she stops working. Grace periods may be granted if there is a change in the person's medical condition that makes him or her temporarily unable to perform his or her job duties, or if he or she lost their job because of circumstances where he or she was not

at fault (e.g., layoff, termination due to behavioral issues related to the person's disability).

Individuals with qualifying reasons for not working may be granted up to six months of grace period time in a 12-month period. The six-month limit may be comprised of multiple grace periods, provided the total grace period time does not exceed six months. During grace periods, the individual remains eligible for Medicaid coverage through MBI-WPD; if an individual does not return work when the six-month limit has been reached, or if it is determined at some point during the grace period that the individual will not or cannot return to work at all, he or she is not eligible to continue to participate in MBI-WPD.

To apply for a grace period, the individual or his or her Medicaid Service Coordinator (MSC) must submit a request to the applicable Medicaid district. Grace period request forms must be obtained from the local district. An example of the form used for individuals with District 98 Medicaid can be found on page 198. All MBI-WPD participants are initially enrolled in the Basic Group and, if subsequent medical improvement merits, individuals are moved to the Medical Improvement Group. Most individuals served by OPWDD and its voluntary providers will remain in the Basic Group due to the nature of their disabilities. If, during a regular continuing disability review (CDR), an individual is determined to be medically improved, the individual will receive notification from the respective Medicaid district. MBI-WPD participants in the Medical Improvement Group must meet additional program requirements, including working at least 40 hours per month and earning at least the Federal Minimum Wage amount (currently $7.25 per hour).

Medicaid Managed Care

Managed care is a health care system that coordinates the provision, quality and cost of care for its enrolled members. When an individual joins a managed care plan, that individual selects a doctor, often referred to as a primary care practitioner (PCP), who is responsible for coordinating their health care.

Medicaid Managed Care (MMC) offers many New Yorkers a chance to choose a Medicaid health plan that focuses on preventative health care. In most counties, if an individual is eligible for Medicaid, they can join a managed care health plan if one is available. Although it is mandatory for individuals to join a plan in some counties, there are some exceptions to mandatory enrollment (see Enrollment in Medicaid Managed Care below).

Enrollment in an MMC program through a Health Maintenance Organization (HMO), clinic, hospital, or physician group is available at most LDSS offices. After joining a managed care plan, individuals must use participating providers (physicians, therapists, etc.) to access health services.

Services Covered Under Medicaid Managed Care

Medicaid Managed Care covers most of the benefits an individual will need, including all preventative and primary care, inpatient care, and eye care. Individuals with managed care plans can use their Medicaid benefit card to access services that the plan does not cover (carved-out services).

The following services are offered through MMC:

- Hospital services
- Physician services
- Emergency services
- Lab/X-Ray services
- Durable medical equipment, medical/surgical supplies, prosthetics
- Home health care
- Specific to the county or health plan: family planning, emergency transportation, dental care

Note: Individuals enrolled in MMC can receive MSC services and be enrolled in the HCBS Waiver.

Enrollment in Medicaid Managed Care

Enrollment in MMC is required unless an individual meets the criteria for either exempt or excluded categories. *Exempt* individuals can choose if they want to enroll in MMC. *Excluded* individuals are not allowed to enroll in MMC and if they are already enrolled, they must be disenrolled.

The following individuals are *exempt*:

- Individuals enrolled in the HCBS Waiver
- Individuals enrolled in a CAH Waiver
- Individuals residing in ICFs and DCs
- Individuals with characteristics and needs similar to individuals enrolled in a CAH Waiver, HCBS Waiver, or living in ICFs or DCs (commonly referred to as “look-alikes”)

Individuals receiving both Medicaid and Medicare (dual eligibles) are *excluded* from MMC.

SSI beneficiaries in mandatory areas must choose a plan within 90 days of receiving the mailing regarding Medicaid Managed Care. Individuals who do not choose a health plan within this timeframe will be automatically assigned to a health plan.

Additional information regarding Medicaid Managed Care can be found at http://www.health.ny.gov/health_care/managed_care/index.htm.

Managed Long-Term Care

Managed Long-Term Care (MLTC) plans are different from MMC and it is important that individuals and providers understand the differences. While MMC plans, as described above, will pay for OPWDD services or allow fee-for-service payment for these services, MLTC plans will not pay for **any** OPWDD services. Individuals wanting to enroll in a MLTC plan must choose between OPWDD services and the services covered by the MLTC plan as they cannot be enrolled in both at the same time.

Medicaid Extensions and Continuations

Certain individuals may be able to keep Medicaid coverage after losing eligibility for SSI. When a person's SSI is terminated, Medicaid coverage continues until a separate Medicaid eligibility determination is made. This determination is completed by the end of the calendar month following the month in which SSI was terminated.

The following are circumstances under which an individual may be able to retain his or her eligibility for Medicaid after losing SSI eligibility, subject to certain restrictions:

Pickle Amendment

The Pickle Amendment allows an individual to continue to receive Medicaid if he or she lost SSI due to a Social Security Cost of Living Adjustment (COLA).

For continued Medicaid eligibility under the Pickle Amendment, the individual must meet the following criteria:

- At any time after April 1977, the individual was simultaneously entitled to receive both Supplemental Security Income (SSI) and Social Security Retirement, Survivors, or Disability (RSDI) benefits, and subsequently became ineligible for SSI because of an RSDI cost of living adjustment

- The individual is currently eligible for and receiving RSDI

- The individual would be eligible for SSI if the Social Security RSDI COLAs received since the last month that he or she received both RSDI and SSI benefits were disregarded

- The individual must live in an Individualized Residential Alternative (IRA), Community Residence (CR), Family Care home (FC), or at home

Pickle Budgeting Example

Pete, who has a disability and lives in his own apartment, received SSI in 1991 of $20.00 and a Social Security Disability Insurance (SSDI) benefit of $580.00. In 2000, his SSDI benefit increased, because of the COLA, to $600.00. As a result of that increase, Pete was no longer eligible for SSI.

In 2014, Pete's SSDI benefit is $879.00. Pete's Medicaid case is budgeted by "freezing" his SSDI amount at the 1999 level of $580.00.

Under Pickle, the difference between the SSDI amount that Pete received in the last month he was eligible for SSI and his current SSDI amount is exempted in Medicaid budgeting:

Current SSDI amount	$ 879.00
SSDI amount 1999	- 580.00
Exempt amount	$ 299.00

The following is the Medicaid budgeting, both without and with the benefit of Pickle eligibility, which shows the resulting spenddown amounts for comparison:

	Non-Pickle	**Pickle Eligible**
Social Security Disability Benefit	$ 879.00	$ 879.00
General income disregard	- 20.00	- 20.00
Net (countable) unearned income	$ 859.00	$ 859.00
Pickle Exempt Amount		**- 299.00**
Total net (countable) income	$ 859.00	$ 560.00
MA Level for One (2014)	- 809.00	- 809.00
Spenddown Amount	**$ 50.00**	**None**

Disabled Adult Child (DAC) Social Security Beneficiaries

Individuals who lose SSI benefits due to either the initial receipt of Social Security benefits on a parent's work record or a subsequent increase in the Social Security benefits may be able to retain their Medicaid coverage.

To be eligible for Medicaid as a DAC, the individual must:

- Be at least 18 years old
- Have been eligible for SSI based on blindness or disability
- Have become blind or disabled prior to age 22
- Have lost SSI on or after July 1, 1987 as a result of an initial entitlement to or an increase in SSA Disabled Adult Child benefits
- Continue to meet all other SSI eligibility requirements
- Live in an Individualized Residential Alternative (IRA), Community Residence (CR), Family Care (FC) home, or at home

For a person who loses SSI eligibility due to the initial receipt of a DAC benefit or an increase in a DAC benefit, the DAC amount received the month before the month SSI eligibility ceased is used in determining the individual's Medicaid eligibility. A person can be reinstated for special DAC budgeting (after having lost it for not meeting SSI eligibility) in any month in which the person again meets the SSI eligibility requirements.

Refer to the decision chart at the end of this section on page 44 to determine DAC Medicaid eligibility.

DAC Budgeting – Example 1

In 2008 and January 2009, Nadia, an individual with a disability who lives in her own apartment, received SSI. In February 2009, she lost SSI because she began to receive a Social Security Disabled Adult Child (DAC) benefit of $879.00 based on the work record of her father who recently retired.

Nadia lost SSI because of receipt of a new DAC benefit, but she continues to meet all other financial and non-financial SSI eligibility requirements. The full amount of her DAC benefit is exempted in Medicaid budgeting. The following illustrates Medicaid budgeting of Nadia's income with and without DAC budgeting:

	Non-DAC	**DAC Eligible**
Social Security Disability Benefit	$ 879.00	$ 879.00
General income disregard	- 20.00	
DAC Exempt Amount		**- 879.00**
Net (countable) Income	$ 859.00	$ 0.00
MA Level for One (2014)	- 809.00	- 809.00
Excess Income (Spenddown)	**$ 50.00**	**None**

DAC Budgeting – Example 2

In 2006, Betty, who has a disability and lives in her own apartment, received both SSI and SSDI. Betty's Social Security Disability Insurance (SSDI) payment of $350.00 was based on her deceased mother's work record. In January 2014, Betty lost SSI because she began to receive a higher Social Security Disabled Adult Child's (DAC) benefit of $1,100.00 based on the work record of her father who recently retired.

Betty lost SSI because of the $750.00 increase in DAC benefits (i.e., $1,100.00 minus $350.00 = $750.00), but she continues to meet all other financial and non-financial SSI eligibility requirements. This amount of the increase in her DAC benefit is exempted for Medicaid budgeting. The following illustrates Medicaid budgeting of Betty's income with non-DAC budgeting and DAC-eligible budgeting:

	Non-DAC	DAC-Eligible
Social Security Disability Benefit	$1,100.00	$1,100.00
General income disregard	- 20.00	- 20.00
		$1,080.00
DAC Exempt Amount		**- 750.00**
Net (countable) income	$1,080.00	$ 330.00
MA Level for One (2014)	- 809.00	- 809.00
Excess Income (Spenddown)	**$ 271.00**	**None**

Section 1619(b): Medicaid Coverage for Working Individuals who Lose SSI

SSI recipients are often concerned that they will lose Medicaid if they go to work. Section 1619(b) of the Social Security Act provides some protection for these individuals by continuing Medicaid coverage if the individuals lost SSI payments because of earned income. To qualify for this continuing Medicaid coverage, a person must meet the following criteria:

- Have been eligible for an SSI cash payment for at least one month
- Still meet the disability requirement
- Still meet all other non-disability requirements for SSI
- Need Medicaid benefits in order to work
- Have gross earnings that are insufficient to replace SSI, Medicaid and publicly funded attendant care services

This means that an SSI beneficiary who loses SSI cash payments because of high earnings may be eligible for Medicaid if he or she meets 1619(b) requirements. SSA uses a threshold amount to measure whether the person's earnings are high enough to replace his or her SSI and Medicaid benefits. The threshold amounts are updated annually, and are published in the SSA Red Book (if you need a copy of the Red Book, contact the Social Security Administration at www.ssa.gov or www.socialsecurity.gov). A person who loses 1619(b) eligibility due to high wages can request that SSA calculate an individualized threshold using the person's actual medical expenses.

For continued Medicaid eligibility, former SSI recipients in any of the three groups described above must remain otherwise eligible for SSI. If a 1619(b) individual's resources exceed the SSI resource level (currently $2,000) for a year or longer, the individual's 1619(b) status is terminated, and the Medicaid continuation ends.

If an individual is no longer eligible under 1619(b) due to assets, the individual may apply for the MBI-WPD program.

If the person no longer meets the disability requirement, the 1619(b) status is terminated immediately. In addition, if it becomes evident that Medicaid is no longer needed for the person to work, the 1619(b) status will end. For a DAC or Pickle individual who ceases to remain otherwise eligible for SSI, the individual's status will revert to DAC or Pickle even if it takes longer than a year to meet SSI requirements other than income limits.

Maintaining Eligibility

Recertification/Renewal

Medicaid coverage for a person not eligible as an SSI recipient must be recertified at least annually. The individual or his or her authorized representative must complete a recertification form and provide all required documentation. Certain individuals are not required to provide documentation for Medicaid renewal. SSI-related recipients enrolled in the HCBS Waiver who are authorized for Community Coverage with Community-Based Long-Term Care are not required to provide documentation of, but must attest to income, resources and residency changes at the time of Medicaid renewal.

A simplified Medicaid renewal form and mail-in process is available. The computer-generated Medicaid Renewal (Recertification) Form is mailed to the recipient and/or authorized representative with a cover letter to advise the individual that coverage is expiring. The letter explains the need to return the completed renewal form with current information and documentation, if required, to the appropriate LDSS. A paper version of the renewal is also in use.

Prompt response to any Medicaid recertification request is imperative. Failure to do to so may result in termination of the person's Medicaid coverage.

Reporting Changes to the Medicaid District

The individual or the individual's authorized representative must notify the Medicaid district promptly of changes in address, living arrangement, the source or amount of income (including windfalls and lump sums), amount or location of assets, change in disabling condition, or any other factors that might affect Medicaid eligibility or coverage.

County-to-County Moves (Luberto)

When an individual moves from one county to another, the sending county (county **from** which the individual is moving) continues Medicaid coverage for a full month following the month it is notified by the Medicaid recipient of the move. The receiving county (county **to** which the individual is moving) opens Medicaid coverage based on the original county's existing authorization period (usually 12 months). The receiving county keeps Medicaid coverage open until the person's next scheduled Medicaid recertification or for a minimum of four months.

Medicaid recipients must notify their sending county in writing of their move and their new address for this policy to apply. The policy does not apply to the following:

- Supplemental Security Income recipients (there is an existing automated process to move coverage to the receiving county)

- Individuals moving from a chronic care setting (e.g., ICF, hospital, psychiatric center, or nursing home)

- Individuals being placed into a residence where OPWDD (District 98) or OMH (District 97) is the Medicaid district

Medicaid Denial, Case Closing, or Reduction of Benefits

If an individual does not agree with the denial of his or her application, termination of coverage, or reduction in benefits, he or she has the right to appeal the determination. The applicant may request a local conference, a fair hearing, or both.

The purpose of a local conference is to review information provided, discuss the basis for the decision, answer questions and seek to resolve any misunderstandings. If the worker determines that an incorrect decision was made, a corrected notice is prepared and given to the applicant and necessary action is taken to activate or correct the individual's Medicaid coverage.

If a fair hearing is needed, the request must be filed within 60 days of the notice date on the Notice of Decision. If the request is not received by DOH by the deadline, DOH may choose not to hear the complaint. If a request for a fair hearing is filed before the Notice of Decision takes effect (within 10 days), Medicaid coverage, if already in place, must be continued unchanged until the fair hearing decision is issued.

Requesting a Fair Hearing

Individuals can ask for a fair hearing by:

- Telephoning the statewide toll-free number: (800) 342-3334
- Faxing: (518) 473-6735
- Online at: www.otda.state.ny.us/oah/forms.asp
- Writing to: The Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201

Receipt of Services

When Medicaid has been authorized, a recipient will receive a permanent plastic Client Benefit Identification Card (CBIC) that must be presented when receiving medical services from a Medicaid enrolled provider:

CBIC (Front)

CBIC (Back)

This card gives the provider the identifying information needed to verify the recipient's eligibility on the date the service is provided. The provider will also be able to determine if there is Medicare or other health insurance coverage that may be available to pay for the service. Since Medicaid is the payer of last resort, other sources of coverage must be used before the service is billed to Medicaid.

When a new CBIC card is issued to an individual, any previously issued cards are invalidated.

Note: Once an individual or his or her authorized representative files a Medicaid application, he or she must use Medicaid enrolled providers because Medicaid only pays for services from such providers. This does not apply to programs or residences that have transportation included in their rate (e.g., IRA, CR, DC, ICF) unless it is emergency transportation or a physician orders special transportation – in those cases, prior approval must be obtained for Medicaid to pay to pay the transportation claim.

For individuals with Medicaid through a local district, requests for prior approval must be made with their transportation unit or, if a local district uses NYS DOH contracted transportation management, through the transportation management provider. If it is unknown whether the county uses NYS DOH contracted transportation management, the provider should contact the local district.

For District 98 (OPWDD) Medicaid recipients, OPWDD's Central Operations processes prior approvals for transportation unless a District 98 Medicaid recipient resides in a county that uses NYS DOH contracted transportation management; in that case, requests for prior approval should be made to the transportation management provider.

Medicaid coverage may be available for services needed outside New York State if the out-of-state provider has enrolled with New York State as a Medicaid provider. Prior to traveling outside the state, a Medicaid recipient or his or her representative should determine the location s of New York State Medicaid enrolled providers in or near the travel destination. This can be accomplished by contacting the provider or by inquiring about a particular provider at the LDSS office.

Examples

Example 1 – Calculating Spenddown

Rashid is 30 years old, has a disability, and lives in Family Care in Westchester County. He receives a monthly Social Security payment of $1,012 and has no earned income. Rashid has incurred medical expenses of $200 for this month. His spenddown calculation is as follows:

Social Security payment:	$ 1,012.00
Less general income disregard:	- $ 20.00
Monthly net (countable) income:	**$ 992.00**
Less Medicaid income level:	- $ 809.00
Spenddown (excess income):	**$ 183.00**

By presenting his medical bills to the Medicaid district, Rashid is eligible for Medicaid coverage for this month.

MBI-WPD Examples

Examples 1 and 2 show budgeting for earned income only, and Examples 3 and 4 show budgeting for a combination of earned and unearned income. Example 5 illustrates how an individual may be able to eliminate a spenddown by participating in the MBI-WPD program. All of these examples are based on the current program limits and assume a resource level of under $20,000 (the current resource limit for this program).

MBI-WPD – Example 1

Monthly gross wages:	*$4,299.00*
Monthly earned income:	$4,299.00
Less general income disregard:	- $ 20.00
	$4,279.00
Less earned income disregard:	- $ 65.00
	$4,214.00
Less one-half remaining earned income:	÷ 2
Monthly net (countable) income:	**$2,107.00**

This individual is eligible for Medicaid through the MBI-WPD program. Although gross income is significantly higher than the limit, the individual's **countable** income is under $2,432 per month.

MBI-WPD – Example 2

Monthly gross wages:	*$5,000.00*
Monthly earned income:	$5,000.00
Less general income disregard	- $ 20.00
	$4,980.00
Less earned income disregard:	- $ 65.00
	$4,915.00

Less one-half remaining earned income:	÷ 2
Monthly net (countable) income:	**$2,457.50**

This individual is not eligible for Medicaid through the MBI-WPD program because countable income exceeds $2,432 per month.

MBI-WPD – Example 3

Monthly SSDI payment:	*$1,200.00*
Monthly gross wages:	*$ 250.00*
Monthly unearned income:	$1,200.00
Less general income disregard:	- $ 20.00
Net (countable) unearned income:	$1,180.00
Gross monthly earned income:	$ 250.00
Less earned income disregard:	- $ 65.00
	$ 185.00
Less one-half remaining earned income:	÷ 2
Monthly net (countable) income:	$ 92.50
Countable unearned income:	$1,180.00
Countable earned income:	+ $ 92.50
Monthly net (countable) income:	**$1,272.50**

This individual would be eligible for the MBI-WPD program because countable income is under $2,432 per month.

MBI-WPD – Example 4

Monthly SSDI payment:	*$2,100.00*
Monthly gross wages:	*$1,000.00*
Monthly unearned income:	$ 2,100.00
Less general income disregard	- $ 20.00
Net (countable) unearned income	$ 2,080.00
Gross monthly earned income:	$1,000.00
Less unearned income disregard:	- $ 65.00
	$ 935.00
Less one-half remaining earned income:	÷ 2
Monthly net (countable) income:	$ 467.50
Countable unearned income:	$2,080.00
Countable earned income:	+ $ 467.50
Monthly net (countable) income:	**$2,547.50**

This individual is not eligible for the MBI-WPD program because countable income is over $2,432 per month.

Eligibility for the MBI-WPD program may effectively eliminate a spenddown. Because the Medicaid income and resource levels are higher for MBI-WPD program participants, individuals who would not otherwise be eligible for Medicaid may qualify through this program. A premium may be required for Medicaid coverage for those at the higher income levels, but at present, New York State is not requiring payment of a premium for individuals in the MBI-WPD program. The following example compares participating in MBI-WPD with obtaining eligibility for Medicaid with a spenddown:

MBI-WPD – Example 5

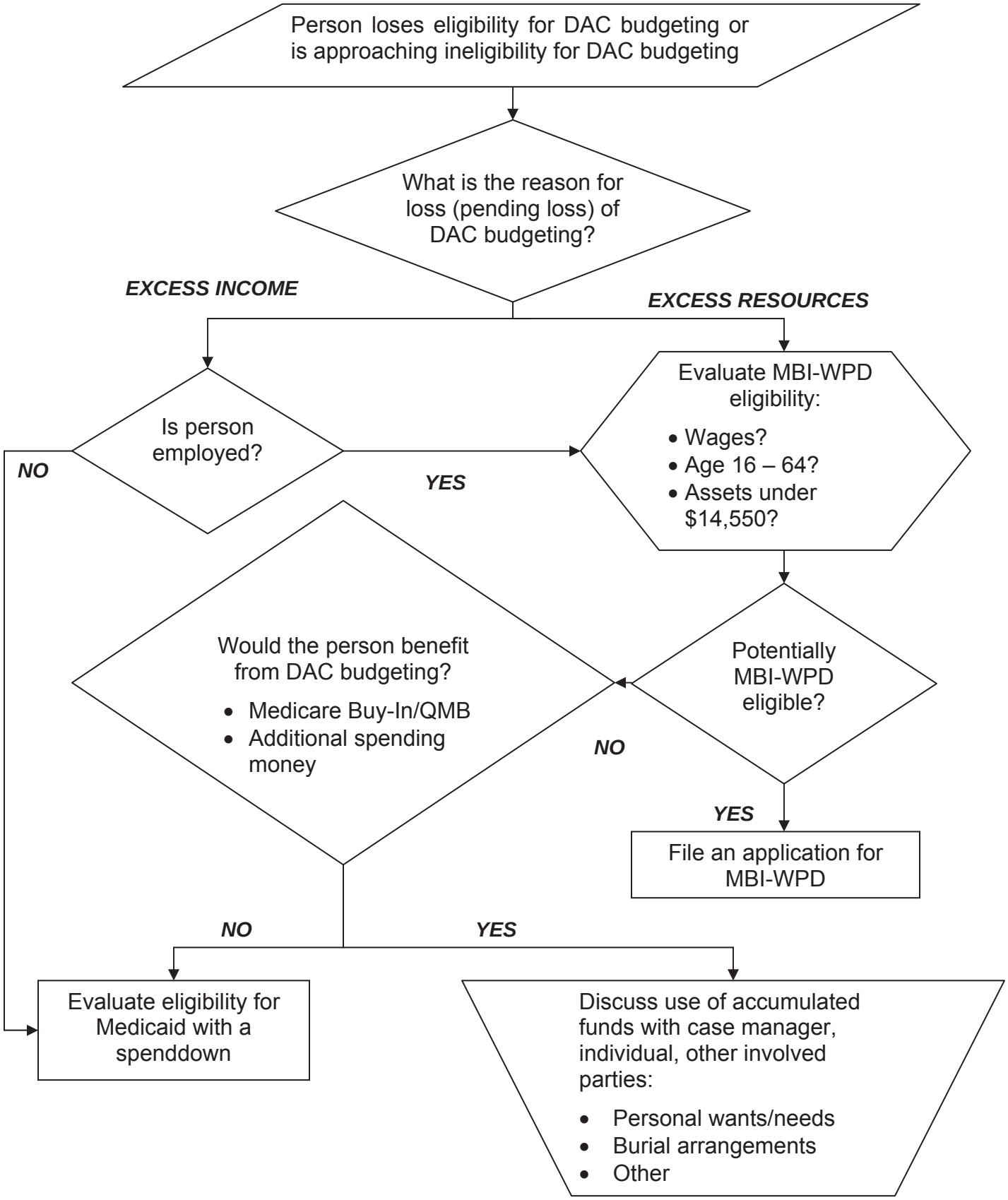
Gary is 27 years old, has a disability and lives alone. In 2014, he receives a monthly Social Security Disability Insurance (SSDI) benefit of $1,000 and works in a workshop. His gross monthly wages are $50. He has a monthly Medicaid spenddown of $183. Gary also has a bank account of $3,825.

Should Gary apply for Medicaid under the MBI-WPD program?

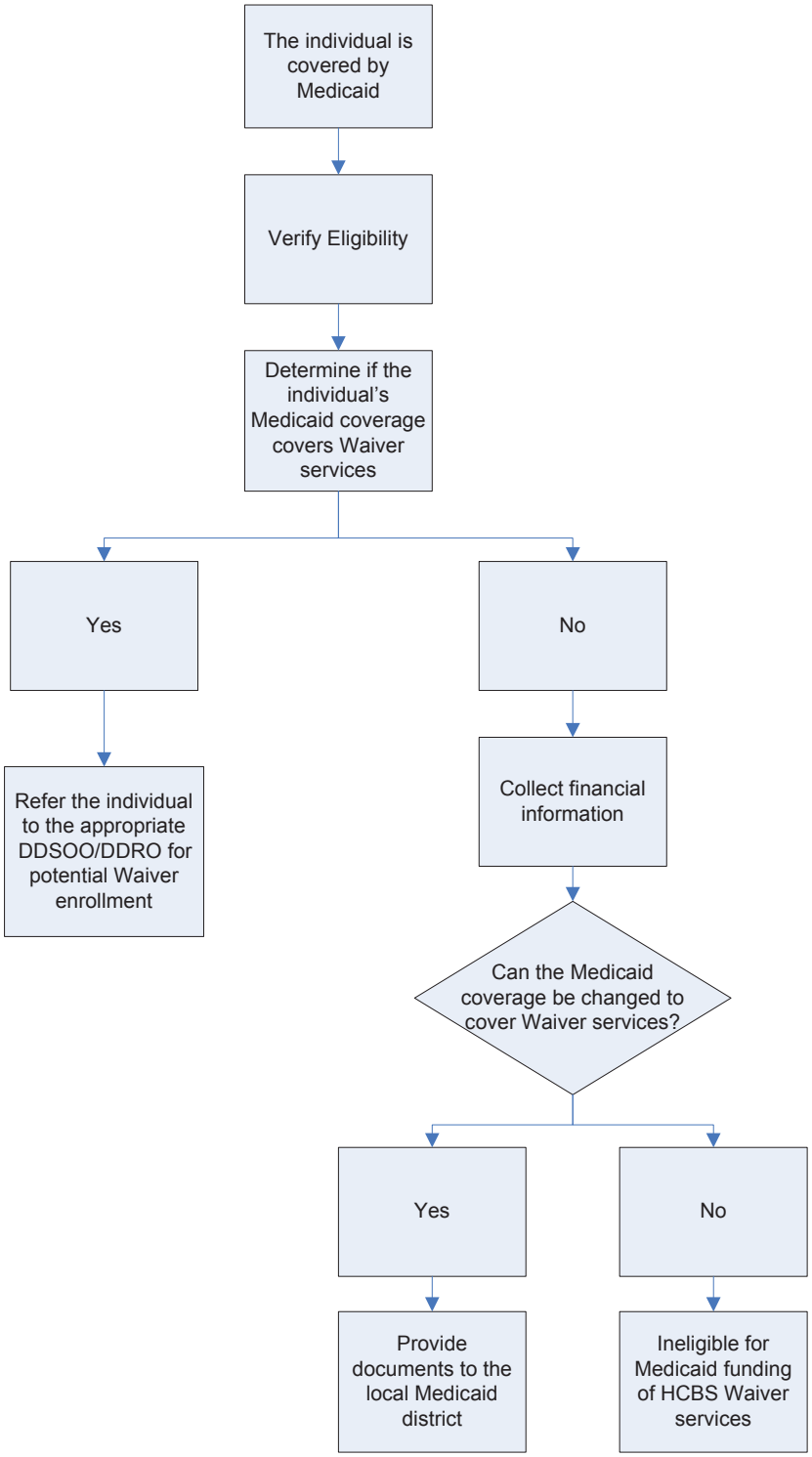
	SPENDDOWN BUDGETING	**MBI-WPD BUDGETING**
SSDI	$1,000.00	$1,000.00
General income disregard	- $ 20.00	- $ 20.00
Net (countable) unearned income	$ 980.00	$ 980.00
Total gross monthly earnings	$ 50.00	$ 50.00
$65 earned income exclusion	- $ 65.00	- $ 65.00
Net (countable) earned income	None	None
Total net (countable) monthly income	$ 980.00	$ 980.00
MA Level for One (2014)	- $ 809.00	
Spenddown amount	**$ 171.00**	

In the example above, Gary has been paying $171.00 using the spenddown budgeting process, which he would not have to pay if he were enrolled in the MBI-WPD program.

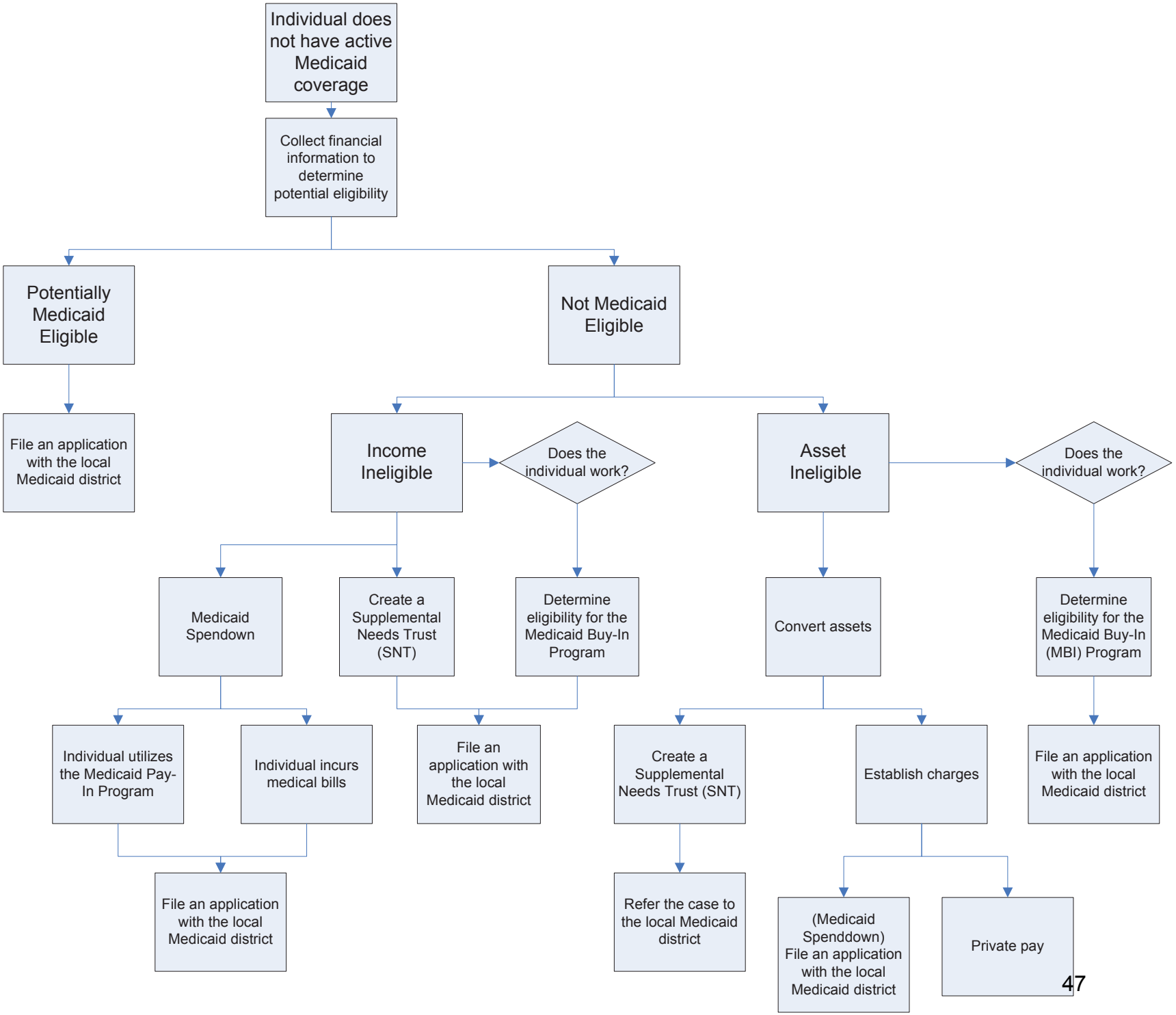
DAC Decision Tree



Individuals with Medicaid coverage



Individuals without Medicaid coverage



Child Health Plus

Child Health Plus (CHPlus) is New York State's free or low-cost health insurance for children up to age 19 who are not eligible for Medicaid. Children enrolled received care through managed care plans. Under CHPlus, there is no fee-for-service component and **OPWDD services <u>are not</u> covered**. Information regarding CHPlus is included here because it may be useful for family members of individuals served by OPWDD.

Depending on the family's income, a child not eligible for Medicaid may qualify for Child Health Plus. Information about this program can be obtained by calling 1-800-698-4KIDS (1-800-698-4543), and asking about Child Health Plus. Information, including income charts, can also be found at the New York State Department of Health's website at: http://www.health.ny.gov/health_care/child_health_plus/.

Child Health Plus covers the following services:

- Well-child care
- Physical exams
- Immunizations
- Diagnosis and treatment of illness and injury
- X-ray and lab tests
- Outpatient surgery
- Emergency care
- Prescription and non-prescription drugs if ordered
- Inpatient hospital medical or surgical care
- Short-term therapeutic outpatient services (chemotherapy, hemodialysis)
- Inpatient and outpatient treatment for alcoholism and substance abuse, and mental health
- Dental care
- Vision care
- Speech and hearing
- Durable medical equipment
- Emergency ambulance transportation to a hospital
- Hospice

Application Process

Applying for Child Health Plus is done through the New York State of Health (NYSOH) website at https://nystateofhealth.ny.gov/. In order to determine what coverage a person qualifies for and whether help to pay for it is available, the following information may be requested:

- Social Security numbers (or document numbers for legal immigrants who need health insurance)
- Birth dates
- Employer and income information for everyone in your family
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Assistance with the application process is available through In-Person Assistors (IPAs), Navigators and Certified Application Counselors (CACs), all of which are trained and certified by the New York State Department of Health.

IPAs/Navigators provide in-person enrollment assistance to people who would like help applying for health insurance through the Marketplace. Assistance is provided in convenient, community-based locations and is free. A list of IPA/Navigator Site locations can be found at: http://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations.

CACs are also trained to provide enrollment assistance to individuals applying for coverage through the Marketplace, and may work in places like hospitals, clinics, providers and health plans. More information about CACs, including where they are located, can be obtained by calling 1-855-355-5777.

Home and Community Based Waiver Services

What is a Waiver Service?

The Home and Community Based Services (HCBS) is one of many waivers granted to states that administer the Medicaid program. The "Waiver" refers to foregoing certain eligibility requirements usually associated with the services provided in order to make them accessible to individuals within a home or in the community.

About the Home and Community Based Services Waiver

The HCBS Waiver has been OPWDD's primary financing mechanism for the Individualized Service Environment (see below). Implemented in September 1991, this federal Medicaid program provided the financial catalyst for OPWDD's system transformation. It has been the key to the doorway to successful living in the community. Tens of thousands of people have moved from segregated congregate care facilities to live as an integral part of the community, thanks in great measure to the supports and services funded through the HCBS Waiver.

About the Individualized Service Environment

New York State's Individualized Service Environment (ISE) is a doorway to successful living in the community for people who have developmental disabilities. The ISE allows the design of uniquely tailored packages of supports and services that help each person pursue his or her goals in life. An individual's independence and inclusion in the community are primary concerns in designing these packages, as is the productive use of personal time. The Office For People With Developmental Disabilities (OPWDD) has developed the ISE in collaboration with individuals, families and providers.

Requesting Services – Basics before Enrollment

An individual who has a developmental disability and lives in New York State can request services funded by OPWDD in a variety of ways. The individual and his or her family can: 1) call OPWDD directly, 2) ask a local government agency to assist them in accessing OPWDD funded services, or 3) have a not-for-profit agency make such a request on their behalf.

This request can begin with something as simple as a telephone call or it can begin with an office visit where forms are completed. With the individual's or family's agreement, it can also be integrated into a service funding proposal submitted by an agency which has been selected to deliver the support or service.

OPWDD's interest is in making it as easy as possible for the individual to begin a dialogue about what supports or services he or she is seeking, and whether they can be provided through OPWDD funding.

Any such requests are reviewed by staff in one of OPWDD's Developmental Disabilities Services Offices (DDSOO) or Service Delivery and Integrated Solutions (REGIONAL OFFICE). Regardless of the type of support or service requested and individual eligibility, each request is considered within the framework of the DDSOO/DDRO funding decisions related to the Community Services Plan (CSP). This plan review process applies to all requests for OPWDD services (HCBS Waiver services as well as all other services).

All decisions to authorize funding for requested supports or services will be based on the three main criteria used in the CSP process:

- Verification of a formal diagnosis of developmental disability
- Matching the needs presented by the individual with established priorities for funding[1]
- Determination that sufficient funding is available to pay for any agreed upon supports or services

Final decisions about enrolling any person in the HCBS Waiver are based on the CSP process. Specifically requesting HCBS enrollment as part of the initial request provides no advantage with regard to the three basic criteria used in CSP funding decisions. Once a decision has been made that the individual requesting services will or should submit an application for enrollment in the HCBS Waiver, a number of procedural tasks and steps are triggered.

Eligibility Requirements for the HCBS Waiver

At the time of enrollment, the individual must reside at home or in a certified Family Care home (FC), Community Residence (CR), or Individualized Residential Alternative (IRA). As a rule, Waiver services cannot be provided until the individual is actually living in one of the above situations. On a limited basis, exceptions may be granted for service coordination and Environmental Modification services when the individual lives in an ICF/MR, Skilled Nursing Facility (SNF), or hospital. This does not preclude an individual who is still residing in an ICF, SNF, or hospital from applying for the Waiver, but participation in the Waiver program cannot begin until the individual is discharged from institutional care.

In order to receive Waiver services, an individual must be approved by the DDSOO/DDRO for enrollment in the HCBS Waiver. To be approved for enrollment, three basic criteria must be met:

- The individual must be eligible

[1] The approved HCBS Waiver application is an agreement between the State of New York and the Centers for Medicare and Medicaid Services on, among other things, the number of eligible people who can be enrolled in the Waiver during any given year. That number is associated with the funding levels available in the state through the annual budget appropriation.

- He or she must meet any priority categories established through an OPWDD sanctioned local planning process
- Medicaid funding for his or her supports and services must be available

DDSOO/DDRO authorization is based on evidence of the following:

- Developmental disability
- Eligibility for Intermediate Care Facility/mental retardation (ICF/MR) level of care
- Medicaid enrollment
- Local enrollment
- Local priorities
- Availability of requested services and funding
- Appropriate living arrangement
- Choice of HCBS Waiver services in preference to care in an ICF

Steps to Enrollment in the HCBS Waiver Program

Step 1 – Decision to Apply for the HCBS Waiver

An individual who has a developmental disability may seek access to any OPWDD funded supports or services, including HCBS Waiver Services. The decision to participate in the HCBS Waiver or access other supports is an individual's choice. Some individuals will make this decision by themselves. Others will decide with the assistance of an interested party – a family member, friend, legal guardian, member of the community, or other person who has a significant relationship with the individual.

Note: The individual will also select a Medicaid Service Coordinator (MSC) or Plan of Care Support Services provider at this time (see Plan of Care Support Services (PCSS) on page 58).

Step 2 – Completion of the HCBS Application Packet

The individual and those assisting him or her to apply for the HCBS Waiver are responsible for completing certain elements of this packet. Those elements include:

- HCBS Application form (HCBS Form 02.01.97)
- Documentation of Choices form (HCBS Form 02.03.97) (the identity of the chosen advocate is indicated on the signature line of this form)
- Preliminary Individualized Service Plan form (HCBS Form 02.04.97)

These forms can be found in the Additional Resources section (Application for Participation in the OPWDD Home and Community Based Services Waiver, page 221, HCBS Documentation of Choices, page 222, and HCBS Waiver Preliminary Individualized Service Plan, page 223).

The individual and those assisting him or her are responsible for making sure that all supporting clinical information and verification of Medicaid eligibility are completed and

submitted to the DDSOO/DDRO in a timely fashion. This is an important responsibility. Until such information is submitted, the DDSOO/DDRO or other designated parties cannot complete other elements of the application process (ICF/MR Level of Care Eligibility and Documentation of Medicaid Eligibility). As a result, the DDSOO/DDRO will be unable to begin its formal review of the application, even though the 90-day time limit (which begins with the submission of the individual's application) would be in effect (see below).

Once an individual, the individual's authorized representative and service coordinator inform the DDSOO/DDRO that the individual wants to apply for the HCBS Waiver, a formal Medicaid timeframe takes effect. DDSOO/DDRO staff will record this date on the Application for Participating form (HCBS Form 02.01.97) as the "Date of stated intent to apply for HCBS Waiver services". This means that the DDSOO/DDRO has 90 days from that point to make a decision and issue a Notice of Decision (HCBS Forms 02.05.97, 02.06.97 and 02.07.97). The DDSOO/DDRO is expected to make decisions well before the 90 days are up unless there is difficulty gathering the necessary information from the individual or the people assisting him or her. HCBS Waiver Coordinators are individuals at OPWDD who can assist with questions and issues that may arise. The most current contact information for the HCBS Waiver Coordinators can be found on the OPWDD website at http://www.opwdd.ny.gov/node/2113.

For its part, since the DDSOO/DDRO has only 90 days to make a decision from the point in time that they were notified that the individual wishes to receive HCBS services, the DDSOO/DDRO also needs to ensure that the Level of Care determination and Medicaid eligibility verification are completed in a timely manner.

Step 3 - DDSOO/DDRO Reviews Pack for Completeness

All documentation described in this section will be maintained along with the ISP in the individual's record by the service coordinator. A copy will be maintained at the DDSOO/DDRO.

The HCBS Application Packet, when completed, will contain all the information and documentation necessary for OPWDD to determine whether a person can be enrolled in the HCBS Waiver.

In order to receive any services from OPWDD a person must have a formal diagnosis of mental retardation or other developmental disability. The onset of this disability must have been manifested prior to age 22. Verification should be assured at the time the person presents himself or herself to OPWDD to minimize unnecessary paperwork for the individual. If the person has a developmental disability, this is documented on the ICF/MR Level of Care Eligibility Determination Form (HCBS Form 02.02.97) as described below.

The required elements of an application are as follows:

- Application for Participation Form

- Documentation of ICF/MR Level of Care Eligibility
- Documentation of Medicaid Eligibility
- Individual's Advocacy Choice
- Preliminary Individualized Service Plan
- Assurance of Informed Choice

Application for Participation Form

The individual and those assisting him or her to apply for the HCBS Waiver are responsible for completing this element of the packet.

Documentation of ICF/MR Level of Care Eligibility

An ICF/MR Level of Care Eligibility Determination Form must be completed within 30 days of the date the DDSOO/DDRO receives the individual's signed Application for Participation. This allows the final decision to be made within the periods specified above. This evaluation will be completed by a qualified staff person using a process and criteria explained in instructions to the form.

To be qualified to make this evaluation, staff must have a minimum of one year of experience in the performance of assessments and development of plans of care for persons with developmental disabilities. The DDSOO/DDRO will decide whether DDSOO/DDRO staff completes the level of care form, or whether staff from other specified agencies will be given this authorization.

An individual who is determined by a second step review to be on Alternate Care Determination (ACD) status is not eligible for Waiver services. However, if there is clinical documentation that the person's condition has significantly changed since the ACD, a new level of care determination (for Waiver eligibility) may be considered. Clearly, this action should occur infrequently, on an exception basis, and with written clinical justification.

Documentation of Medicaid Eligibility

To participate in the Waiver, an individual must be enrolled in Medicaid. This is indicated by inclusion of the person's Medicaid Client Identification Number (CIN) on the application form. The DDSOO/DDRO will verify current Medicaid eligibility.

Information on applying for Medicaid for adults or individuals under 18 years of age who do not live with their parents is included in the Medicaid section of this manual.

Waiver of Parental Deeming

Individuals seeking Waiver services who will continue to live with their parents can have Medicaid eligibility determined based on their own assets.

Section 1902(a)(10)(c)(i)(lll) of the Social Security Act allows Medicaid eligibility to be determined without regard to parental income and resources. This waiver is not necessary to determine eligibility for individuals age 18 or above who live with their parents or for individuals of any age living outside of the family household.

When determining eligibility for children who are certified blind or disabled under the age of 18 years, districts must disregard parental income and resources and compare only the child's income and resources to the Medicaid eligibility level.

Note: If a determination of disability has not been done, it must be completed as part of the application process.

These individuals must complete the following process:

1. The DDSOO/DDRO informs the OPWDD Revenue Support Field Office (RSFO) staff that the individual must file for Medicaid (MA) with the Local Department of Social Services (LDSS) office.

2. The DDSOO/DDRO will ensure that the individual meets all conditions for Waiver enrollment (except MA eligibility) prior to sending him or her to the LDSS office.

3. The RSFO staff gives the applicant a referral letter to present to the LDSS office. The RSFO staff will also contact the LDSS office and arrange for a Medicaid appointment for the individual and interested parties, if appropriate.

4. The Medicaid eligibility process will be performed by the responsible LDSS office.

5. After a determination has been made by the LDSS office regarding Medicaid eligibility, the LDSS office will send a copy of the Notice of Decision on Your Medical Assistance Application to the RSFO. The RSFO will then contact the DDSOO/DDRO advising them of this decision.

Note: For individuals under 18 who are living with their families and enrolling in Medicaid as part of the HCBS application process, the effective date for HCBS enrollment must be the same as the effective date for Medicaid enrollment.

Individual's Advocacy Choice

OPWDD assumes that all people with developmental disabilities have some capacity for self-advocacy and decision-making. This is one of the fundamental values of the ISE. In addition, OPWDD assumes that some people with disabilities are capable of self-advocacy in the service planning process. If an individual indicates that he or she is capable of self-advocacy in the service planning process, the DDSOO/DDRO will validate this in accordance with 14 NYCRR 633.99 (person, capable adult). If the individual has an advocate, this person is identified at this point in the enrollment process. Those not capable of self-advocacy must have an advocate. The identity of the chosen advocate should be indicated in the signature block on the Documentation of Choices form (HCBS Form 02.03.97).

Preliminary Individualized Service Plan

As part of the application process, individuals must tell OPWDD what supports and services they believe they need, and why. The "why" should explain briefly how the

requested supports and services would help the individual achieve desired valued outcomes and pursue his or her personal goals.

The Preliminary Individualized Service Plan (PISP) is a plan that briefly identifies the applicant's personal goals related to the ISE, and the supports, services, and activities the individual proposes to select in pursuit of those goals. There must be a general "fit" between the individual's personal goals, preferences, interests, needs, and capabilities and the identified activities, supports, and services that could make up his or her ISE. To the extent that unusual safeguards or protections are related to an individual, they should be included as well. The intent is to indicate that natural supports, Medicaid State Plan Services, HCBS Waiver services, and other services are used appropriately, in a reasonable and proper balance. The PISP should minimally provide a description of the services that will need DDSOO/DDRO funding (Step 4 below explains how the DDSOO/DDRO reviews the PISP).

The level of detail required in a PISP is less than the level that will be required of the final Individualized Service Plan (ISP). The PISP is a brief, "first cut" description of the individual and what he or she wants. Service coordinators, with the individual and his or her advocate, will use the PISP as a starting point to develop a comprehensive ISP. The Centers for Medicare and Medicaid Services (CMS) accept the abbreviated PISP format to substantiate billing for the first 60 days of service delivery, after which a comprehensive ISP is required.

The individual and his or her advocate must be afforded the opportunity to make informed decisions in the development of the preliminary plan. The service coordinator will build on this process for the development of the ISP. If possible, the chosen service coordinator should participate in the development of the PISP.

Assurance of Informed Choice

Informed choice is a fundamental and critical part of the HCBS Waiver application process. The Documentation of Choices form, with appropriate signatures, assures that informed choices were made.

Step 4 - DDSOO/DDRO Issues a Notice of Decision

The DDSOO/DDRO evaluates all eligibility factors and then informs the individual of approval or denial of the application by issuing a Notice of Decision within 90 days on behalf of the "single state Medicaid agency". The Notice of Decision also advises the individual with disabilities and his or her advocate of the right to appeal an adverse decision by requesting a Medicaid Fair Hearing.

If the application is approved, the Notice of Decision is sent to the individual, with copies to the parties listed on the form. Please note that a copy is sent to the LDSS office that has fiscal responsibility for the individual. If this office is not in the county where the individual resides, an additional copy must also be sent to the LDSS office in the individual's county of residence.

At times, it will be necessary for a DDSOO/DDRO to deny the application for enrollment in the HCBS Waiver. This decision should be made only by the Director and Associate Commissioner after the individual or his or her advocate are offered an opportunity to discuss the reasons for the possible denial and supply any additional supporting information that may cause the DDSOO/DDRO to rethink its position. At the time that the Director and Associate Commissioner make the decision to deny enrollment, a Notice of Decision is issued which indicates the reason(s) for denial. It identifies to the individual the reason for denial and that he or she has the right to request a conference and/or a Medicaid Fair Hearing on this denial.

At this point, the enrollment process is completed.

Termination of Individual Enrollment in HCBS Waiver

The service coordinator is responsible for initiating the process of terminating the enrollment of a participant in HCBS Waiver services by notifying the DDSOO/DDRO when any of the following occurs:

- The individual chooses not to receive the services any longer
- The individual is no longer eligible for HCBS Waiver services because he or she is no longer eligible for Medicaid
- The individual is permanently admitted to an ICF (including a Developmental Center), a community-based ICF, a Small Residential Unit (SRU), a specialty hospital, a Skilled Nursing Facility (SNF), or a psychiatric center.

Once enrolled in the HCBS Waiver, it is very unlikely that an individual will be terminated from the Waiver unless one of the situations mentioned above should apply. When the DDSOO/DDRO Director and Associate Commissioner initiate the termination of enrollment, the DDSOO/DDRO issues the Notice of Decision, which identifies the reasons for termination and advises the individual and advocate of the right to request a Medicaid fair hearing. The notice is to be sent to the:

- Individual (unless death is the reason for termination)
- Individual's advocate
- Service coordinator (case manager)
- DDSOO/DDRO staff who input data into TABS
- Providers of Waiver services to the individual
- LDSS of fiscal responsibility (LDSS in the county of residence must also be notified when that county is different from the county that bears fiscal responsibility for the individual)

The Notice of Decision – HCBS Waiver Termination must be mailed at least 10 days prior to the effective date of termination. If the individual requests a fair hearing and "aid continuing" prior to the effective date of termination, the Office of Temporary and Disability Assistance will determine whether the individual is entitled to have his or her

current services continue unchanged pending a fair hearing decision. The DDSOO/DDRO should consult with Counsel's Office prior to terminating services in such cases.

Once termination of services occurs, three things will happen:

1. Providers will cease delivering Waiver services to the individual,

2. No bills will be submitted to Medicaid for services delivered after the termination date, and

3. The individual's name will be deleted from administrative rolls in order to free up that Waiver opportunity for someone else. OPWDD RSFO staff will "end date" the HCBS Waiver code in the Welfare Management System (WMS).

Note: Services may continue if the individual's termination is under appeal (see below).

DDSOO/DDRO staff must ensure that the date of termination is noted in TABS. If the reason for termination of services is Medicaid ineligibility, then the termination date is the date indicated on the Notice of Intent to Discontinue Medical Assistance issued by the Local Department of Social Services. In all other cases, the termination date is the date service delivery ends.

If an individual transfers from one DDSOO/DDRO to another and plans to continue HCBS Waiver services, it is not necessary to terminate enrollment. Staff at the involved DDSOO/DDRO, however, must make the necessary changes in TABS to reflect the transfer. They must also notify the appropriate LDSS office of the move.

Suspension of Services versus Termination

Any of the circumstances listed at the beginning of the above section could lead to termination from the Waiver. However, termination is not required if the individual is expected to return to HCBS services within a reasonable period. For instance, if he or she is no longer eligible for the HCBS Waiver because Medicaid eligibility has lapsed due to time-limited income, and the person expects to be re-enrolled in Medicaid in a short while, termination is not required. Termination of the delivery and billing of HCBS services is required, but the person can remain administratively enrolled in the HCBS Waiver.

This "suspension of HCBS services" allows an individual to avoid lengthy re-enrollment proceedings. If the absence from the Waiver is due to changes in eligibility status, the individual must document that the required eligibility criteria have been met (re-enrollment in Medicaid, for the example above).

There is a time limit that must be used in any "suspension of HCBS services". OPWDD has decided that, without cause, the suspension of HCBS services cannot exceed 75 days. If, at the end of 75 days, the individual and service coordinator cannot

demonstrate to the DDSOO/DDRO's satisfaction that the individual will return to the Waiver shortly, the DDSOO/DDRO should issue a Notice of Decision – HCBS Waiver Termination form. If the DDSOO/DDRO agrees to extend the enrollment beyond this 75-day limit, such extensions must be in writing and reviewed every 30 days thereafter.

Enrollment and Due Process Rights

Certain HCBS related actions of the DDSOO/DDRO require that the individual be notified of his or her rights to a fair hearing under Medicaid. Those actions include:

1. Authorization of Enrollment
2. Denial of Application
3. Termination of HCBS Enrollment

Should any of the above actions occur, the DDSOO/DDRO must issue the appropriate Notice of Decision, which includes language notifying the individual that he or she has the right to request a Medicaid fair hearing. A Medicaid fair hearing is requested through the Office of Temporary and Disability Assistance. Individuals who will be terminated from HCBS are entitled to continue receiving current Waiver services, also known as "aid continuing", if they request a fair hearing prior to the effective date indicated on the Notice of Decision. In such cases, HCBS Waiver services continue unchanged until the hearing is withdrawn or a final decision is issued. The Notices of Decision include the appropriate language as well as information on how to contact the appropriate offices. Decision forms are located at the DDSOO/DDRO.

Plan of Care Support Services

Plan of Care Support Services (PCSS) is required for individuals who are enrolled in the HCBS Waiver and whose decision not to receive Medicaid Service Coordination (MSC) is approved by the DDSOO/DDRO. A person receiving PCSS cannot be enrolled in any other Medicaid funded service coordination program.

Purpose of PCSS

The purpose of PCSS is to provide two essential services usually performed by a service coordinator that will allow the person to maintain his or her eligibility for the HCBS Waiver. The first is reviewing and updating the ISP twice a year. The second is coordinating the completion of the annual ICF/MR Level of Care Eligibility Determination Form. PCSS is a limited, task-specific service that is not ongoing in nature. It is not the same as service coordination.

An individual's or family's decision to not receive service coordination must be an informed choice. Service coordinators should inform Waiver participants who do not want to receive MSC about the PCSS requirements and the limited service available through PCSS. If a person requests or needs more services than PCSS can provide, MSC should be considered.

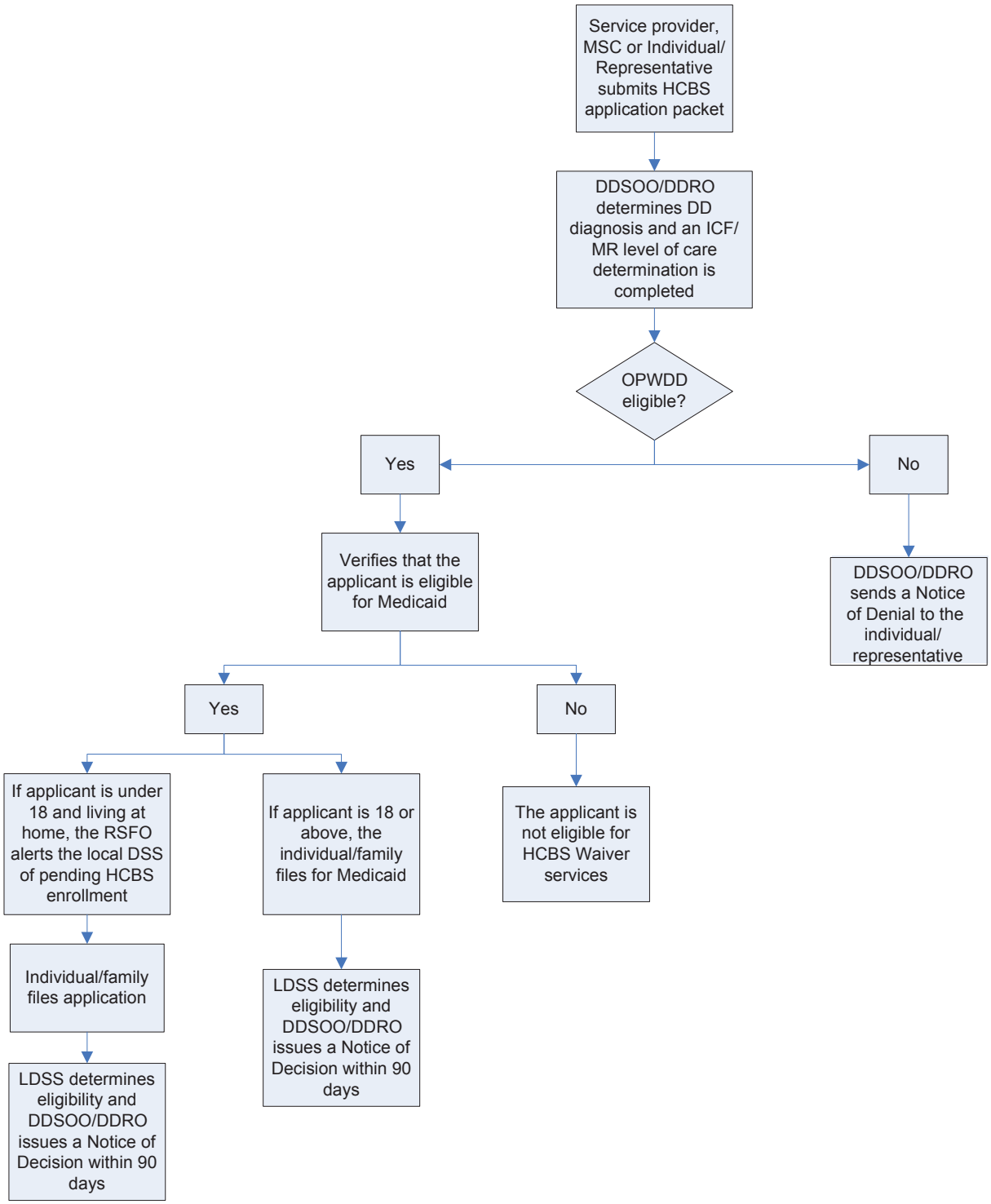
PCSS Providers

PCSS can be provided by OPWDD or a voluntary not-for-profit provider with an HCBS Waiver provider agreement. Staff providing PCSS must meet MSC qualifications for service coordinators, including training requirements. These requirements can be found in Chapter 2 of the MSC Vendor Manual available on the OPWDD website: www.opwdd.ny.gov.

PCSS Service Delivery

PCSS is provided at the time the ISP is due for review (at least twice a year). Agencies providing PCSS can bill Medicaid once every six months. A face-to-face visit with the person at a mutually convenient location is also required every six months.

HCBS Waiver Enrollment Process



Supplemental Security Income

What is Supplemental Security Income?

Supplemental Security Income (SSI) is a needs-based benefit program. The Social Security Administration (SSA) pays monthly SSI benefits to supplement the income of people with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children, as well as adults, can get SSI benefits.

Note: Supplemental Security Income is separate and distinct from Social Security benefits (SSDI) which will be discussed in the Social Security Benefits section, beginning on page 107.

This section explains what SSI is, who can get it, and how to apply for it. It provides basic information and is not intended to answer all questions. Detailed information about SSI Benefits is provided in the booklet, "Understanding Supplemental Security Income" at www.socialsecurity.gov/ssi or through the information line 1-800-772-1213.

When a voluntary agency or other representative develops SSI benefits for individuals they must fully cooperate with the Social Security Administration and support individuals by helping to:

- Establish potential eligibility for SSI
- Assist in the completion of the SSI application
- Manage SSI benefits when appointed representative payee

Eligibility Requirements for Supplemental Security Income

Since SSI is a needs-based program, financial eligibility for SSI depends on what an individual owns and how much income he or she has. If the individual is married and living with his or her spouse, SSA also looks at the income of the spouse and the things he or she owns. If an individual is under age 18 and living with his or her parents, SSA may look at the income and resources of the parents. If the individual is a sponsored non-citizen, SSA may look at the income of the non-citizen's sponsor and what he or she owns.

The table on the following page gives an overview of the criteria that an individual must meet in order to be eligible for Supplemental Security Income.

Section 6: Supplemental Security Income

To be eligible for SSI, an individual must meet the following criteria:

Aged	65 or older
OR	
Blind	Adult or child with 20/200 vision or less in the better eye with best correction, or visual field of 20 degrees or less, even with corrective lens
OR	
Disabled	Adult: o Unable to work due to a physical or mental impairment that has lasted or is expected to last at least one year or to result in death Child: o Has a physical or mental condition(s) that is expected to last at least one year or to result in death o Under age 18 who has a physical or mental condition(s) that can be medically proven and which results in marked and severe functional limitations o Age 18-22 and meets the disability definition for adults
AND	
All of the following requirements: o Limited income o Limited resources ($2,000 for an individual, $3,000 for a couple) o U.S. citizen or eligible qualified non-citizen o Resident of the U.S., including the District of Columbia and the Northern Mariana Islands o Agree to apply for other benefits o Meet certain other requirements	

SSI Eligibility requirements regarding a person's income, resources and living arrangements are discussed in detail on the pages that follow.

Income Requirements for SSI Eligibility

Whether an individual can get SSI depends on his or her income. If an applicant has income, he or she may need to document the following:

- Earned Income - wages, earnings from self-employment, certain royalties/ honoraria and sheltered workshop payments

- Unearned Income - Social Security benefits, pensions, Worker's Compensation payments, Veterans' benefits, Railroad Retirement benefits, unemployment benefits, interest income, dividends, and cash from friends and relatives

- In-Kind Income - food or shelter the individual gets free or for less than its fair market value

SSA first determines eligibility for SSI by using the federal eligibility test. This test compares countable income to the Federal Benefit Rate (FBR) for a specific month. If countable income is less than or equal to the FBR, the individual or couple meets the income test.

The SSA will disregard and not count some types of income, or a portion of the income, when deciding if an individual can get SSI.

Exclusions from Income

The following amounts are disregarded for the purposes of determining SSI eligibility:

- The first $20 of most income received in a month
- The first $65 of earnings and one half of earnings over $65 received in a month
- SNAP
- Shelter the individual gets from private nonprofit organizations
- Most home energy assistance
- Some of the wages or scholarships a student receives
- Wages a disabled individual uses, subject to SSA approval, to pay for items or services the person needs in order to work. For example, if the individual must take a taxi to work instead of public transportation due to his or her medical condition, the wages he or she uses to pay for the taxi do not count as income.
- Wages a blind individual uses, subject to SSA approval, to pay expenses that are related to working. For example, if a blind individual uses wages to pay for transportation to and from work, the transportation cost is not counted as income.

A complete list of what SSA does not count toward income can be found in the "Understanding Supplemental Security Income" booklet, available at www.ssa.gov.

Infrequent and Irregular Income

SSA also excludes, for SSI purposes, income that is received either infrequently or irregularly.

Infrequent income is income received no more than once in a calendar quarter from a single source.

Irregular Income is income that the individual could not reasonably expect to receive.

The SSI exclusion for infrequent or irregular income applies to earned and unearned income and is limited to the first $30 per calendar quarter of earned income and the first $60 per calendar quarter of unearned income.

IDENTIFYING INFREQUENT OR IRREGULAR UNEARNED AND EARNED INCOME

Benefit Payments Beginning July 1, 2004

UNEARNED INCOME Payment Frequency	Other criteria	Type
No more than once in a calendar quarter from a single source		Infrequent
No more than once in a calendar quarter from each of several sources	It is the same type of income in each instance	Infrequent
No more than once in a calendar quarter from each of several sources	It is a different type of income in each instance	Infrequent
More than once in a calendar quarter from the same source	It is a different type of income in each instance	Infrequent
More than once in a calendar quarter from the same source	It is the same type of income in each instance	**Not** infrequent
Any number of times in a calendar quarter	The individual could not reasonably have expected or budgeted for it	Irregular
Any number of times in a calendar quarter	The individual could reasonably have expected or budgeted for it (even if the individual did not know the exact amount)	**Not** irregular

EARNED INCOME Payment Frequency	Type
No more than once in a calendar quarter from a single source or from each of several sources	Infrequent
More than once in a calendar quarter from a single source or from each of several sources	**Not** infrequent
Any number of times in a calendar quarter and the individual could not reasonably have expected or budgeted for it	Irregular
Any number of times in a calendar quarter and the individual could reasonably have expected or budgeted for it (even if the individual did not know the exact amount)	**Not** irregular

Resource Requirements for SSI Eligibility

The value of the applicant's resources is one of the factors that determine whether he or she is eligible for SSI benefits. Resources are things an individual owns such as:

- Cash
- Bank accounts, stocks, U.S. savings bonds
- Trusts
- Land
- Life insurance
- Individual's property
- Vehicle(s)
- Anything else the individual owns that could be converted to cash and used for food or shelter
- Deemed resources (see Deeming Eligibility Guidelines on page 84 for an explanation)

The Resource Limit

The limit for countable resources is $2,000 for an individual and $3,000 for a couple. If the individual owns property or another resource that he or she is trying to sell, the individual may be able to get SSI while trying to sell the resource. SSI does not consider everything an individual owns as a countable resource.

The SSA will disregard and not count some types of resources, or a portion of the resources, when deciding if an individual can get SSI.

Exclusions from Resources

The following items are excluded from the individual's resources when determining SSI eligibility:

- The individual's home, the land it is on and other buildings on that land as long as the individual is residing in the home or planning to return to the home if temporarily absent. There are other circumstances that would allow the home to remain excluded. Check www.ssa.gov for more information.

- Household goods and individual's property[2]

[2] Household goods are items used on a regular basis or needed by the householder for maintenance, use and occupancy of the premises as a home. Furniture, appliances, personal computer, television set, and dishes are some of the items considered household goods. Personal property refers to items ordinarily worn or carried by the individual and includes personal jewelry as well as educational and recreational items such as books or musical instruments. SSI does not exclude items acquired or held for their value or as investments.

- One car if it is used for transportation of the individual or a member of the individual's household
- Exception trusts (also known as supplemental needs trusts)
    - SSA must be sent a copy of the trust agreement for review.
    - If the agreement does not include a provision for Medicaid as remainderman, SSA will not exclude the trust.
- Burial spaces for the individual or his or her spouse
- Burial funds (to be used for burial expenses) for the individual and his or her spouse, each valued at $1,500 or less (principal)
    - If non-burial space items are included in a pre-need burial agreement, the total value of these items is deducted from the $1,500 burial fund limit. Interest on excluded burial funds does not count if left to accumulate as part of the burial fund, e.g., a bank account specifically identified as a burial fund
    - Life insurance may reduce the amount of a burial fund that can be excluded
- Life insurance policies that accrue cash value and that have combined face values totaling $1,500 or less. This amount counts toward the individual's $1,500 burial fund limit
- An irrevocable pre-need burial agreement
- A SSA-approved Plan to Achieve Self Support (PASS) that allows the individual to save money over and above the SSI resource limit without affecting his or her SSI eligibility
- Retroactive SSI or Social Security benefits for nine months following the month of receipt, including payments received in installments (retroactive payments of Social Security benefits are countable income in the month of receipt and exempt resources for the next nine months)

Additional information about resources is available in the booklet "Understanding Supplemental Security Income", which can be found at www.socialsecurity.gov.

Burial Spaces

SSI has a resource exclusion solely related to a burial plot or space for the recipient or his or her spouse. This is known as the burial space exclusion. This exclusion is in addition to, and has no effect on, a burial fund exclusion. Unlike the burial fund described below, the burial space exclusion has no dollar limit. Burial space exclusions include the following items:

- Burial Plot
- Gravesite
- Crypt
- Mausoleum
- Casket
- Urn
- Niche
- Other repository customarily and traditionally used for the deceased's bodily remains

The burial space exclusion also includes any necessary and reasonable improvements to the space, such as (but not limited to):

- Vaults
- Headstones
- Markers
- Plaques
- Burial containers
- Arrangements for opening and closing the gravesite
- Perpetual care of the gravesite

Burial Funds

A burial fund is money or other resources that can be readily designated or converted to cash for paying for a person's burial expenses or those of his or her spouse. This money is excluded by SSI as a resource up to a maximum of $1,500.00 in principal.

Within this limit, burial funds can be designated for the following:

- The burial expenses of the SSI recipient

- The burial expenses of the SSI recipient's spouse (whether or not the spouse is eligible for SSI)

A person can designate resources as a burial fund by doing any of the following:

- Indicating on the document that the resource is a burial fund (e.g., the title on a bank account)

- Completing form SSA-4169

- Indicating on the SSA-8000-BK (question 29) or SSA-8203-BK (question 22 (b)) or in the remarks section of either form that the resource is a burial fund

A signed statement may also be used to designate a burial fund only if it contains the following information:

- The value and owner of the resources
- The person for whom the burial fund has been established
- The type of resource (burial contract, bank account, life insurance policy, etc.)
- The date that the resource was set aside as a burial fund

The burial fund exclusion is separate from and in addition to the burial space exclusion. The $1,500.00 burial fund exclusion, however, may also include the payments on installment contracts for burial space items that do not qualify for the burial space exclusion because the individual does not currently own the space, does not have the right currently to use the space, and the seller is not currently obligated to provide the space.

The following reduces the maximum $1,500.00 that can be excluded for burial funds:

- The face values of life insurance policies on the individual (or spouse, if applicable) that accrue cash values

- Any amount held in a pre-need irrevocable burial agreement, burial contract, or other irrevocable arrangement for the individual's (or spouse's) burial expenses except the amount for excludable burial space items

Purchase of an excluded life insurance policy or an irrevocable burial contract reduces the amount of the available burial fund exclusion. If life insurance is purchased after other burial funds or arrangements have been set up, the reduction in the amount of the available burial fund exclusion is effective the month after the month in which the life insurance or the irrevocable burial contract was purchased.

For SSI purposes, burial insurance is an irrevocable arrangement whose face value reduces the $1,500.00 burial fund exclusion by the policy's face value. A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than payment of the insured’s burial expenses. **NOTE:** If a policy has a Cash Surrender Value to which the owner has access, the policy is not burial insurance for SSI purposes.

Any appreciation in the value of an excluded burial fund is excluded from resources (and from income), even if the total of the burial fund thus excluded exceeds $1,500.00. This includes interest earned by the burial fund, provided the interest is left to accumulate as part of the fund.

Once a fund is designated as a burial fund, it remains such for SSI purposes until either of the following occurs:

- SSI eligibility ends

- The individual uses the fund for another purpose (A penalty may apply in this situation)

A burial fund should not be commingled with assets intended for other purposes. If such funds are commingled, the burial fund assets will not be excluded.

Inappropriate Use of Excluded Burial Funds

A penalty will be applied, except as noted below, if an individual uses an excluded burial fund for a purpose other than the burial arrangements of the individual or the individual's spouse for whom the fund was set aside. The amount of the penalty, which cannot be appealed, is equal to the amount used for non-burial purposes. The penalty will be withheld from future SSI payments.

No penalty applies if, as of the first day of the month in which the excluded funds were used for another purpose, the individual's resources would not have exceeded the limit, even if the burial fund were not excluded.

Transferring an excluded burial fund from one form to another (e.g., from a designated bank account to a burial contract) is not considered use of a burial fund for another purpose.

Only actions (i.e., use for another purpose) by the individual who designated the excluded burial fund or by someone acting as that individual's agent result in a penalty. Actions by a joint owner of a financial instrument who is not the individual or agent (e.g., a joint owner of a designated bank account who withdraws funds for his or her own use) do not result in a penalty.

A loan against the cash surrender value of a life insurance policy that has been designated for burial expenses **is not** use for another purpose **if** the loan is for the purchase of another burial fund. Use of a burial fund as collateral for a loan **is** use for another purpose because the loan creates an encumbrance on the funds. Since the funds are not available for the individual's burial as long as they are encumbered, the funds cannot be considered set aside for the individual's burial. This is true even if the loan is used for burial purposes.

If a burial fund is used for another purpose, a re-designation of the funds may be necessary. Re-designation does not mean that the burial fund exclusion is lost and reapplied, but that the dollar amount in the original designation must be changed or corrected. Re-designation becomes necessary at the point that there is a change in the amount of funds originally designated (not including accumulated interest or appreciation).

Example 1 - Burial Exclusions

Susan has a Pre-Need Funeral Arrangement with a local funeral home that includes non-burial space items funded at $200.00. She also has a savings account of $1,000.00 designated as a burial fund. Can Susan put aside additional burial resources without jeopardizing her SSI benefits?

Maximum exclusion for burial expenses	$1,500.00
Less non-burial space items in Pre-Need Funeral Arrangement	- 200.00
Remaining available exclusion	$1,300.00
Less designated Burial Fund	- 1,000.00
Still available for exclusion	$ 300.00

SSA excludes $200.00 of the Pre-Need Funeral Arrangement and the $1,000.00 designated burial fund. Two years later, Susan wants to add to her designated burial fund, which now increased to $1,150.00 due to accumulated interest. Susan can increase the excluded funds in the account by the $300.00 that is still available for exclusion.

The addition of $300.00 brings the total designated burial fund (less interest) to $1,300.00. SSA disregards the amount of interest that accumulated in the account.

Maximum exclusion for burial expenses	$1,500.00
Less non-burial space items in Pre-Need Funeral Arrangement	- 200.00
Remaining available exclusion	$1,300.00
Less designated Burial Fund	- 1,300.00
Still available for exclusion	$ 0.00

Example 2 - Burial Exclusions

Mallory has a bank account containing $1,200.00. Of this, she considers $500.00 as being for her funeral expenses and the remaining $700.00 as available for her living expenses.

Is this account excludable for SSI?

No, the account is not excludable. The $500.00 that is intended for burial may **not** be excluded as a burial fund while it is commingled with other savings. If the $500.00 is moved to a separate account and designated as a burial fund, the exclusion may be applicable the month following the month in which the funds are separated.

Transfer of Resources

To determine an individual's eligibility for SSI, the Social Security Administration confirms the value of the individual's resources at the first moment of the month. The determination of resources is made at the time of application for SSI, and is evaluated periodically for each month that SSI payments were made.

Transferring ownership of a resource may affect the amount of an individual's countable resources and, in turn, can affect his or her SSI eligibility. When an asset is validly transferred, the individual no longer owns it. For SSI purposes, if the individual no longer owns the asset, it is not counted as a resource. An invalid transfer is one in which the person appears to have transferred the resource but actually continues to own it. For SSI purposes, the invalidly transferred resource is counted as a resource for the individual.

A valid transfer of resource ownership is one that may occur through any of the following:

- Sale of property
- Trade or exchange of one asset for another
- Spending - absent evidence to the contrary, SSI assumes that an individual gets fair market value when he or she spends cash resources
- Giving away cash (e.g., a gift)
- Transferring any financial instrument (e.g., stocks, bonds)
- Giving away a resource including adding another person's name as an owner of the resource
- Transferring an inheritance (in the month it is received)

A valid transfer of ownership of a resource for less than fair market value will result in a period of ineligibility for SSI. The period of SSI ineligibility may be up to 36 months. When the Social Security Administration is advised that an individual transferred a resource, they determine the effect of that transfer on the individual's SSI eligibility. SSA must also notify state Medicaid agencies about resource transfers, regardless of when the transfer occurred.

Note: If the transfer violates the Medicaid rules, the individual may remain eligible for a SSI cash benefit, but ineligible for Medicaid.

When a transfer has occurred, SSI obtains a signed statement from the applicant or beneficiary to determine whether the transfer of a resource was valid. The individual's signed statement must provide information regarding the following:

- The nature of the transfer (sold, given away, traded, etc.)
- The method of transfer (sold on open market, transferred without compensation, etc.)
- The date of the transfer

- A description of the transferred resource
- The amount of cash transferred or the current market value of the transferred resource
- The amount and type of compensation received
- Any remaining ownership interest

If the individual is not sure of the exact date of the transfer, SSI will verify the date and validity of any transfer that is alleged to have occurred on or before December 1, 1999. SSI will request copies of available evidence of the transaction such as:

- Bills of sale
- Receipts for prepayment of rent
- Signed statement by the person to whom the property was transferred
- A signed statement by the person transferring the property and only if the evidence above cannot be obtained and the sale was on the open market (that is, not to a relative)

For transfers alleged to have occurred before December 1, 1999, SSI will verify the transfer only if the individual's allegation is questionable or the individual cannot remember the date of transfer.

SSI Treatment of Dividends and Interest

Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts. Dividends and interest may be countable income or excluded income for SSI purposes, depending on the resource and other circumstances.

The following chart describes when dividends or interest are considered countable income or excluded income:

SSI TREATMENT OF DIVIDENDS AND INTEREST		
When the source of the dividend or interest is...	**Pursuant to…**	**Then...**
A countable resource	* See below	The dividends or interest is excluded income
An excluded resource	A federal statute other than the Social Security Act	The dividends or interest is excluded income
An excluded resource	§1613(a) of the Social Security Act	See chart below

* For the SSI program, not everything an individual owns is a resource and not all resources count against the SSI resource limit. The Social Security Act and other federal statutes require the exclusion of certain types and amounts of resources. Any

resources that are not specifically excluded are "countable". See page 65 for additional information regarding resources that are excluded.

EXCLUDED RESOURCES PURSUANT TO §1613(a) OF THE SOCIAL SECURITY ACT	
Source of Resource	**Treatment of Interest**
Advance Earned Income Tax Credit (EITC) payments	Interest earned on unspent EITC - Countable
Child Tax Credits (CTC)	Interest earned on unspent CTC - Countable
Earned Income Tax Credits	Interest earned on unspent EITC – Countable
Gifts to children with life-threatening conditions	Countable
Excluded educational assistance payments except educational assistance under Title IV of the Higher Education Act or the Bureau of Indian Affairs	Countable
Relocation assistance, unspent	Countable
Replacement of excluded resources	Excluded for the period that the cash or in-kind support provided as the replacement is excluded Countable when the unspent cash or in-kind support provided as the replacement is countable
Retroactive payments (SSDI and SSI)	Countable during nine-month period the retroactive payments are not counted (SSDI) Countable once the nine-month period ends (SSI)
Victim's compensation	Countable

Lump Sum, Windfall, and Retroactive Payments

See the Medicaid section for information regarding how lump sum, windfall and retroactive payments are considered for SSI-related individuals.

Windfall Offset Provision

In addition to the treatment of retroactive lump sum payments described in the Medicaid section referenced above, when making retroactive Social Security benefit payments to

an SSI recipient, SSA applies an offset to the individual's retroactive Social Security benefits based on the total SSI amount paid to the individual during the retroactive period. The total amount of SSI paid during the months covered by a retroactive Social Security benefit is more than the amount of SSI that would have been paid to the individual if he or she had actually received Social Security benefits in each of those months. The retroactive Social Security payment is therefore reduced by the difference between the two SSI amounts, known as the offset.

The offset is calculated by subtracting the total SSI amount that would have been due if the Social Security benefit had been paid during the period from the total SSI amount that was actually paid. The amount of the offset is then subtracted from the retroactive Social Security payment:

SSI amount paid
- SSI that would have been paid
Offset amount

Retroactive Social Security benefit amount
- Offset amount
Net lump sum payment

If the retroactive Social Security benefit is less than the SSI offset amount, the retroactive payment will be the $20.00 general income disregard for each month of the retroactive period.

Living Arrangement Requirements for SSI Eligibility

The individual's living arrangement is another factor SSA will use to determine the maximum amount of SSI that he or she can receive. There are specific SSI payment levels for each of the following living arrangements:

- Living alone – the individual's own place, such as a house, apartment, or trailer
- Someone else's household (living with others, living in the household of another)
- A congregate care or board and care facility (OPWDD, OMH, OASAS certified residence)
    - Congregate Care Level 1 – Family Care
    - Congregate Care Level 2 – Community Residence, Individualized Residential Alternative
    - Congregate Care Level 3 – Enhanced Residential Care including OPWDD certified Schools for the Mentally Retarded
- An institution where Medicaid provides more than 50% of the cost, including Intermediate Care Facilities and Developmental Centers

Because where a person lives affects the amount of his or her SSI payment amount, when an individual moves between certified residences, his or her SSI payment may increase or decrease based on the types of living arrangements or the regions of the state in which the residences are located.

The SSI benefit levels for each category of living arrangements for individuals for 2014 are provided in the Attachments section (2014 SSI Benefit Levels, page 225). The charts also show the federal benefit rate and the state supplements.

Note: The Social Security Administration pays the Congregate Care Level 2 only if the VOIRA or VOCR program site is listed in the Congregate Care Directory. When a new Congregate Care Level 2 site is first opened, it takes between 8 and 12 weeks for the site to be added to the directory. The SSA field offices can check with their Region II contact about six weeks after the operating certificate is issued. Once the site is listed in the directory or the SSA Region 2 contact has confirmed the site as a Congregate Care Level 2 program, the individual will be paid at the Congregate Care Level 2 amount retroactive to the month of placement if the individual was already receiving an SSI benefit or the month following the month the SSI application was filed if the individual was not an SSI recipient prior to placement. If the application was filed before the month of placement, the individual will be paid SSI the month following the month of eligibility (generally the month of placement). Free-Standing Respite Homes do not appear in the Congregate Care Directory and individuals residing in them are not eligible for the Congregate Care 2 level payment.

Under certain living situations, the recipient's SSI payment level may be reduced. The following are some examples of those situations:

- The recipient lives in another person's house, apartment, or trailer, and pays less than his or her fair share of food or housing costs

- The recipient lives in his or her own house, apartment, or trailer, and someone else pays for all or part of the recipient's food, rent or mortgage, and other shelter costs such as electricity and garbage removal

- The recipient is in a hospital or nursing home for the whole calendar month and Medicaid pays for more than one-half of the bill

  Note: A special rule may apply to continue SSI benefits for a recipient who will be hospitalized or in a nursing home for 90 days or less. A physician must submit a written statement to SSA indicating that the individual will be returning to his or her former living arrangement within 90 days. The recipient or someone knowledgeable about his or her circumstances must provide a statement to SSA that continued SSI benefits are needed to maintain the recipient's home or living arrangement during the period of hospitalization or nursing home confinement. If the individual will not be returning to the same living arrangement such as a

Family Care home, the individual's funds should not be used to pay the Family Care Provider.

- The recipient is in an institution run by a federal, state, or local government for the whole month (in most government institutions, a person cannot get any SSI unless Medicaid is paying more than one-half of the bills).

Although people who live in city or county rest homes, halfway houses or other public institutions usually cannot receive SSI, there are some exceptions. An otherwise eligible individual may receive SSI if he or she:

- Lives in a publicly-operated community residence that serves no more than 16 people
- Lives in a public institution mainly to attend approved educational or job training that will help the individual get a job
- Lives in a public emergency shelter for the homeless
- Is in a public or private institution and Medicaid is paying more than half the cost of his or her care

State Supplementation

The SSI monthly benefit is made up of a federal payment and a supplement financed by New York State. Under the SSI program, states may provide additional benefits to their own recipients in recognition of the variations in living costs from one state to another and for the special needs of some individuals. In NYS, the state supplement is based on the individual's living arrangement. Beginning in October 2014, the NYS Office of Temporary and Disability Assistance (OTDA) will pay the State Supplementation. Information about the OTDA takeover of the state supplement is available at: http://otda.ny.gov/programs/ssp/.

For individuals residing in the community or a congregate care setting, the state supplement is paid by SSA in the same check or direct deposit as the federal portion. For individuals residing in Developmental Centers or Intermediate Care Facilities, OTDA is responsible for paying the $5.00 monthly state supplement, which is paid in a separate check. If an individual resides in a nursing home, the state supplement amount paid by OTDA is $25.00.

To determine eligibility for the optional State supplementary (OSS) payments, countable income is compared to the FBR amount. If it exceeds the FBR amount, the amount by which it does is compared to the OSS level for the applicable living arrangement. The following determinations may be made:

- If an individual or couple meets the federal eligibility test, the individual or couple is eligible for OSS.

- If the excess income is less than the computation month OSS payment level, the individual or couple is eligible for OSS.

- If the excess income is equal to or more than the computation month OSS payment level, the individual or couple is not eligible.

Calculating SSI Payments

The amount of SSI paid to an eligible individual is usually calculated using the person's actual income from two months earlier. This is known as "retrospective monthly accounting" (RMA) and is an accounting method implemented to minimize incorrect SSI payments caused by income changes. Using RMA, SSI payment computation is based on income received in the second month before the month for which payment is being computed. The month for which the payment is being computed is called the computation month. The earlier month from which income amounts are used is referred to as the budget month.

When calculating an individual's SSI payment for a month later than the first three months of eligibility, it is necessary to know the sources and amounts of income the individual received two months earlier and to have all the SSI notices for the person.

The RMA payment calculation method is not applied in three situations:

- When an individual has been eligible for and paid only OSS payments and attains or re-attains eligibility for Federal SSI or when an individual first becomes eligible for Federal SSI or re-attains Federal eligibility after a period of ineligibility, SSI benefits for the first, second and third months are based on countable income in the first month. Beginning the fourth month, regular RMA computation is performed.

- When income received in one month is not received the month after, this is referred to as non-recurring income. If there is non-recurring income, the SSI benefits for the second and third months are based on the countable income from the first month. The non-recurring income amount does not affect the SSI benefit calculation for the second and third months.

- SSI recipients who have Title II (Social Security) income and certain in-kind income are subject to an annual cost of living adjustment (COLA), which usually goes into effect in January of each year. COLA coordination means that a COLA increase for Title II income and certain in-kind income is used immediately to compute SSI for the first two months that the COLA is in effect. The SSI payment calculation for the COLA month applies normal RMA rules for other income.

To calculate SSI payments:

1. Identify all sources and amounts of income actually received two months earlier. For each source of income, determine whether the income is unearned (e.g., Social Security disability or retirement), earned (e.g., wages or salary), or in-kind.

   Compare the actual income amounts with the amounts stated in the most recent SSI payment notice for the individual. If income changes have not been reported promptly to SSA or processed promptly by SSA, the previously estimated income amounts (rather than the actual income amounts) will have been used to calculate the current SSI payment. SSI payments will be adjusted retroactively when SSA enters the actual income amounts into the person's SSI budget.

2. Apply all disregards and exclusions to the income to determine the individual's countable income. Calculate the countable income by subtracting the total applicable disregards and exclusions from the total income.

3. Subtract the countable income from the SSI payment level for the individual's living arrangement to determine the SSI payment amount.

Example 1 – SSI Payment Calculation

Amy lives in an agency-sponsored family care home. She has received SSI since moving to the home two years ago. She receives a Social Security Disability (SSDI) benefit of $500 per month. She has total monthly gross earned income of $100. Her income has been stable for several months. How much will Amy receive in SSI?

In 2014, the maximum SSI cash benefit for an individual in an agency-sponsored family care home in upstate New York is $949.48; in New York City and Nassau, Rockland, Suffolk and Westchester counties, it is $987.48.

1. Determine the countable income by applying applicable disregards and exclusions:

Unearned income (SSDI)	$ 500.00
General income disregard	- 20.00
Countable unearned income	**$ 480.00**
Monthly gross earnings	$ 100.00
Earned income disregard (first $65)	65.00
	$ 35.00
Earned income disregard (one-half the balance)	÷ 2
Countable earned income	**$ 17.50**
Countable Unearned Income	$ 480.00
Countable Earned Income	+ 17.50
Total countable income	**$ 497.50**

2. Calculate the SSI payment by subtracting the countable income from the applicable SSI payment level for the individual's living arrangement:

	Upstate	NYC/Nassau/Rockland/ Suffolk/Westchester
SSI payment level (ASFC)	$ 949.48	$ 987.48
Total countable income	- 497.50	- 497.50
SSI payment	**$ 451.98**	**$ 489.98**

Example 2 - RMA Calculation

Luke is 56 years old and resides at a VOIRA. Luke's SSDI benefits, based on his father's work record, are $325.00 a month effective January 1, 2014. Luke also receives a Workers Compensation benefit of $61.00 a month. Luke has earnings from the sheltered workshop where he is employed. He also receives SSI benefits that vary because of his earnings.

The following chart shows Luke's actual monthly income from April through September.

Monthly Income						
	April	**May**	**June**	**July**	**August**	**Sept**
SSDI	$325.00	$325.00	$325.00	$325.00	$325.00	$325.00
Workers Compensation	$61.00	$61.00	$61.00	$61.00	$61.00	$61.00
Wages	$100.00	$90.00	$95.00	$110.00	$85.00	$105.00

How much SSI will Luke receive in June, July, August, and September?

	June	**July**	**August**	**Sept**
Total Gross Monthly Unearned Income	$325.00 + 61.00 $386.00	$325.00 + 61.00 $386.00	$325.00 + 61.00 $386.00	$325.00 + 61.00 $386.00
Less General Income Disregard	- 20.00	- 20.00	- 20.00	- 20.00
Countable Unearned Income	$366.00	$366.00	$366.00	$366.00
Earned Income	$100.00	$90.00	$95.00	$110.00
Less Earned Income Exclusions $65.00	- 65.00	- 65.00	- 65.00	- 65.00
	$ 35.00	$ 25.00	$ 30.00	$ 45.00
One-half the balance	÷2	÷2	÷2	÷2
Countable Earned Income	$ 17.50	$ 12.50	$ 15.00	$ 22.50
Countable Unearned Income Countable Earned Income	$366.00 + 17.50 $383.50	$366.00 + 12.50 $378.50	$366.00 + 15.00 $381.00	$366.00 + 22.50 $388.50

Total Countable Income				
SSI Benefit Level for VOIRA (Downstate)	$1,156.00	$1,156.00	$1,156.00	$1,156.00
SSI Benefit Level for VOIRA (Upstate)	$1,126.00	$1,126.00	$1,126.00	$1,126.00
Less Total Countable Income	- 383.50	- 378.50	- 381.00	- 388.50
SSI Payment – Downstate	**$ 772.50**	**$ 777.50**	**$ 775.00**	**$ 768.50**
SSI Payment - Upstate	**$ 742.50**	**$ 747.50**	**$ 745.00**	**$ 737.50**

Except as described below, when computing the SSI payment, SSA subtracts the countable income in the budget month from the FBR of the computation month. For individuals in Title XIX facilities, which include developmental centers, intermediate care facilities and special units, the countable income is compared to the $30 payment cap and not the FBR.

If countable income is less than the FBR, a federal SSI payment is due and the full OSS amount would be paid.

If countable income is greater than or equal to the FBR, no federal SSI payment is due. The process then determines eligibility for OSS by calculating the excess income (the difference between countable income in the budget month and the FBR of the computation month):

- If the result is no excess income, the full OSS amount is payable.
- If there is excess income, it is subtracted from the OSS payment level for the computation month and the remainder is the OSS payment.
- If the excess income exceeds the OSS payment level for the computation month, no OSS is payable.

Value of the One-Third Reduction

The applicable FBR is reduced by one-third when an individual or couple lives throughout a month in another person's household and receives both food and shelter from others living in the household. This reduction in FBR has an income value, known as the value of the one-third reduction, or VTR.

There is no partial VTR. The VTR applies in full or not at all. No income exclusions apply to the VTR.

When the VTR applies, no additional in-kind support and maintenance is chargeable against the individual's SSI payment. The VTR may apply even if the individual receives part of his or her food and shelter from inside the household and part from the outside. It is not necessary that an individual receive food and shelter from inside the household on each day of the month for the VTR to apply.

The VTR rate for a couple can continue to apply to both members of a separated eligible couple in the month that they separate.

The VTR does not apply if the individual:

- Lives in his or her own household
- Lives in the household of another but does not receive both food and shelter
- Does not live in a household
- Does not live throughout the entire calendar month in the household of another
- Lives alone

In-kind Support and Maintenance

When a claimant or couple receives in-kind support and maintenance (ISM), but does **not** receive **both** food and shelter from the household in which the claimant or couple lives, the value of the one-third reduction (VTR) rule does not apply and the ISM is valued under the Presumed Maximum Value rule. See www.socialsecurity.gov for more information on ISM and PMV.

Planning for Discharge from a Public Institution

An individual in a public institution where Medicaid does not pay more than 50% of the costs will not be eligible for SSI until he or she leaves the institution. The individual may, however, be able to apply for SSI before release so that SSI payments can begin as soon as possible. The individual or his or her representative should check with the institution about release plans and with SSA about filing an application under the prerelease procedures.

Periodic Redetermination of Eligibility Process

SSA periodically reviews the individual's income, resources, and living arrangement to make sure that he or she is still eligible for SSI and receives the right amount of SSI benefits. SSA will send inquiries and verification requests to the individual.

SSA will also review the income, resources and living arrangements of the individual's spouse or of the parents of a disabled child under age 18 living with them.

Note: SSA initiates a disability redetermination when a child receiving SSI reaches age 18. This disability determination uses adult disability rules.

If medical improvement is expected for an SSI individual, a redetermination may be scheduled within six to 18 months after benefits are awarded. After that, the redetermination of eligibility and payment amount for most SSI recipients is completed every 1 to 7 years.

When an individual or his or her representative reports a change that affects eligibility or payment, SSA reviews the individual's income, resources, and living arrangements. For

example, a review is often completed when the recipient reports a change in marital status.

SSA completes the redetermination process by telephone interview, in person (during a scheduled appointment), or by mail. SSA will send forms SSA-8202BK or SSA-8203BK (Statements for Determining Continuing Eligibility for Supplemental Security Income Payment) to determine future eligibility for SSI benefits.

SSA may ask for one or more of the following documents when reviewing an individual's benefits:

- Savings account, checking account, or other bank statements
- Pay stubs or income tax returns
- Proof of other income (e.g., pensions, annuities, unemployment)
- Life insurance policies
- Burial contracts
- Household receipts (lease, utilities, etc.)

Continuing Disability Review

SSA completes a periodic review of continuing eligibility for SSI benefits, based on disability or blindness. This review is called a continuing disability review (CDR). The frequency and methods of CDRs are based on the specific circumstances of each individual. SSA requires CDR for disabled individuals at least every three years except for cases with permanent disability (SSA determines the appropriate review time for cases involving permanent disability).

SSA will do a CDR at least every three years for disabled children (under age 18) whose conditions are likely to improve, and at no later than 12 months of age for babies whose disability was based on low birth weight.

SSA mails the Disability Update Report (Form SSA-455-OCR-SM or SSA-455) to the individual or his or her representative to complete to determine continuing SSI eligibility based on disability or blindness.

Benefits continue in payment status unless there is strong proof that a person's impairment has medically improved and that he or she is able to return to work. The individual can file an appeal if he or she disagrees with the determination. Otherwise, benefits stop 3 months after the beneficiary is notified that his or her disability ended. Benefits for dependents continue as long as the disabled worker continues to be entitled to benefits. Please note that SSA contracts with the NYS Office of Temporary and Disability Assistance, Division of Disability Determinations to do the disability determinations and reviews. If correspondence is received from this division, any requests should be responded to promptly.

Reporting Responsibilities

The individual or representative payee must notify SSA promptly of changes that might affect continued eligibility for SSI benefits. The change must be reported within ten days after the end of the month in which the change occurred. The report must include the reporter's name, the name and Social Security number of the individual, facts about the change and date of the change.

The individual or representative payee can call 1-800-772-1213 to report changes, or can visit, write or call the local SSA office.

The following are examples of changes that the SSI recipient or representative payee must report:

- Change of address
- Change in living arrangement
- Change in income
- Change in resources
- Death of an individual
- Death of a spouse or anyone in the individual's household
- Change in marital status
- Change in citizenship or immigration status
- Change in help with living expenses from friends or relatives
- Admission to, or discharge from, an institution such as a hospital, nursing home, prison, or jail
- Change in the amount of expenses that have been approved by SSA as IRWE or BWE
- Change in school attendance if under age 22
- Absence from the U.S. for more than 30 consecutive days
- If an arrest warrant has been issued for the individual for fleeing to avoid a felony prosecution or to avoid custody after being convicted of a felony
- If a warrant has been issued for arrest of the individual for a violation of a condition of parole or probation

A disabled individual must also report the following:

- Medical improvement
- Return to work
- Change in the Ticket to Work agreement
- Change in work or Plan to Achieve Self Support (PASS) expenses

Prompt reporting of changes is important to prevent the following:

- The individual may be underpaid and there may be a delay in paying the additional amounts due him or her
- The individual may be overpaid and have to pay back the excess to SSA

- The individual may be charged a penalty for failing to report within the time limit if the individual is his or her own payee

SSI Eligibility for Children

A child can qualify for SSI benefits if he or she meets Social Security's definition of disability for children, and if his or her income and resources fall within the eligibility limits. SSA also considers the family's household income, resources and other personal information. A child must be disabled or blind to be eligible for SSI benefits. For SSI purposes, a child is an individual who is neither married nor head of the household and who:

- Is under age 18
- Is under age 22 and is a student regularly attending school, including a vocational training institution designed to prepare the individual for a paying job

A child under age 18 is considered disabled if he or she has a physical or mental condition or conditions that can be medically proven and that result in marked and severe functional limitations. The conditions must have lasted or be expected to last at least 12 months or to end in death. If the individual is between the ages of 18 and 22, the adult disability definition applies (see SSI eligibility requirements chart on page 62).

The forms SSA-3820-BK Disability Report – Child (page 261) and SSA-3881-BK Questionnaire for Children Claiming SSI Benefits (page 275) must be completed when applying for SSI benefits for children with disabilities.

Deeming Eligibility Guidelines

If a child is under age 18, not married, and lives at home with parents who do not receive SSI payments, a portion of the parents' income or resources may be considered available to the child in determining his or her financial eligibility for SSI. This is called deeming. SSI verifies the age and marital status of an eligible child to determine whether the child is eligible for parental deeming. In New York State, the parent's income and resources are subject to deeming if he or she lives in the same household with an SSI-eligible child and is one of the following:

- The natural parent of the child
- An adoptive parent
- The spouse of the natural or adoptive parent (including a relationship in which the natural or adoptive parent lives with someone and they hold themselves out as a married couple when they are not (e.g., common-law marriage, also known as a "holding out" relationship)

Under deeming, deductions are allowed for the parents and for other children living in the home. After these deductions are subtracted from income, the amount remaining is used to decide if the child meets the SSI income and resource requirements for a

monthly benefit. Deeming stops when a child reaches age 18 or no longer lives with a parent.

The effective month for deeming of a parent's income and resources to an SSI eligible child is based on the individual's circumstances, and is one of the following:

- The month after the month the child comes home to live with the parent(s) (e.g., the month following the month the child comes home from the hospital after his or her birth)
- The month of birth if the child is born in the parent's home
- The month after the month of adoption (the month of adoption is the month the adoption becomes final)
- The month after the month of marriage (e.g., when a natural or adoptive parent marries) or the month after the month a parent begins living in a "holding out" relationship

Deeming does not apply, and SSI may pay up to $30 when all of the following apply:

- A disabled child who received SSI while in an institution goes to live at home
- The child is eligible for Medicaid under a state home care plan, such as the Home and Community Based Services (HCBS) Waiver
- Deeming would otherwise cause ineligibility for SSI. The Waiver of parental deeming under the various Waiver programs, like the HCBS Waiver, applies to Medicaid eligibility only, and does not apply to the SSI program.

Note: If either the child or the parent is temporarily absent from the household (less than 60 days), deeming still applies. SSA does not consider the income of a parent for deeming purposes if the parent receives a public income maintenance payment such as Temporary Assistance to Needy Families (TANF).

Parental Deeming of Income Calculation

The parental deeming amount is calculated based on the following:

- Deduct allocations from unearned income for any non-disabled siblings
- Subtract the $20.00 general income disregard from remaining unearned income to determine the countable unearned income
- Subtract the earned income exclusions from the family's earnings to determine the countable earned income
- Add the countable earned and unearned income to determine the family's total countable income
- Deduct from the total countable income an allocation for the parents' needs, i.e., the FBR for an individual (single parent) or for a couple
- Subtract the general income disregard to calculate the child's countable deemed income

Parental Deeming of Resources Calculation

- Deduct the amount of the SSI resource limit from the parents' countable resources to determine the value of the parents' resources available for deeming
- Allocate deemed resources equally to all developmentally disabled children to determine the child's or children's countable resources

Waiver of Parental Income

The Social Security Administration does not deem parental income and resources to any child under age 18 who meets all of the following:

- Is disabled
- Received, at any time in the past, at least one month's SSI payment (including the state supplement) while residing in or admitted to a hospital, extended care facility, nursing home, or intermediate care facility that is a certified inpatient provider under a Medicaid state plan
- Is eligible for Medicaid under a state home care plan – for SSI purposes, state home care plans are those:
    - Approved by the Secretary of Health and Human Services under the provisions of section 1915(c) of the Social Security Act relating to waivers (e.g., HCBS Waiver)
    - Or authorized under section 1902(e)(3) of the Social Security Act
- Would be ineligible for SSI benefits because of deemed parental income or resources or would be eligible for an SSI payment lower than $30.00

The eligible child's own income and resources affect SSI eligibility and payment in the usual manner. For example, if the child's countable income (excluding deemed income) exceeds the federal $30.00 payment limit, the child's eligibility is suspended for excess income.

The eligibility requirements for SSI benefits under the waiver of parental deeming provision must be met in the computation month. SSI will determine changes in living arrangements and the value of in-kind support and maintenance for these children as if the usual deeming rules applied.

The purpose of plans under each of these provisions is to provide Medicaid coverage at home for disabled individuals who have been (or could be) institutionalized, but who are able to be cared for at home without a decrease in the quality of care, and at a cost no greater than the cost of care in the institution.

Examples of deeming are shown on the next several pages.

Example 1 – Parental Deeming of Income

Henry, a 10-year-old child with a disability, lives with his mother and father and a 12-year-old brother who is not eligible for SSI. In 2014, Henry's mother receives a pension (unearned income) of $955.00 per month and his father earns $1,185.00 per month. Henry and his brother have no income. The parents own their home and have approximately $2,500.00 in savings.

Is Henry eligible for SSI?

From the family's unearned income, deduct an allocation for Henry's brother's needs, i.e., $361.00 ($361.00 is the difference between the FBR for a couple ($1,082.00), and that for an individual, ($721.00)). From that, subtract the general income disregard Countable unearned income	$955.00 - 361.00 $594.00 - 20.00 $574.00
Apply Earned Income Exclusions to the earned Income: $65.00 One-half the remainder Countable earned income	$1,185.00 - 65.00 $1,120.00 ÷2 $560.00
Calculate the total countable income: Countable unearned income Plus countable earned income Total countable income From the total countable income, deduct an allocation for the parents' needs, i.e., the FBR for a couple ($1,082.00). This amount is deemed as Henry's unearned income Deduct Henry's general income disregard to calculate Henry's countable income	 $574.00 + 560.00 $1,134.00 - 1,082.00 $ 52.00 - 20.00 $ 32.00

SSA compares Henry's countable income to the appropriate SSI Benefit Level for an individual. Depending on circumstances, the SSI Benefit Level could be the Living in the Household of Another rate or the Living with Others rate.

Since Henry's countable income, $32.00, is less than either rate for an individual, Henry is eligible for SSI.

SSA determines Henry's SSI monthly benefit amount by subtracting his countable income, including deemed income, in a prior month from the appropriate SSI payment level for the individual for the current month.

Example 2 – Parental Deeming of Income

James and Tony, are age 9 and 11, respectively; both have a disability and live with their mother. The children have no income but their mother receives a pension of $1,043.00 a month.

Are James and Tony eligible for SSI?

From the unearned income, deduct the $20.00 general income disregard	$1,043.00 - 20.00 $1,023.00
Subtract the amount allocated for the mother's needs, i.e., the FBR for an individual ($721.00). This amount is deemed to James and Tony, and is divided equally between them.	- 721.00 $302.00 ÷ 2 $151.00
For each child, apply the $20.00 general income disregard to his income to calculate his countable unearned Income.	- 20.00 $131.00

SSA compares each child's countable income to the appropriate SSI benefit level for an individual. Depending on circumstances, the SSI benefit level could be the Living in the Household of Another rate or the Living with Others rate.

Since each child's countable income of $131.00 is less than either rate for an individual, each child is eligible for SSI.

SSA determines each child's SSI monthly benefit amount by individually subtracting their countable income in a prior month, including deemed income, from the appropriate SSI payment level for the individual for the current month.

Example 3 – Parental Deeming of Income

Jackson, a 15-year-old child with a disability, lives with his mother, father, and two younger brothers, none of whom is eligible for SSI. Jackson's mother receives a pension of $697.00 per month. His father works and earns $2,285.00 per month.

Is Jackson eligible for SSI?

For each of Jackson's brothers, deduct an allocation for his personal needs from the parents' unearned income. The amount allocated for each brother is $361.00, i.e., the difference between the FBR for a couple ($1,082.00), and that for an individual ($721.00). The total allocation is $722.00 (2 x $361.00).	$697.00 - 722.00 ($ 25.00)
The parents' unearned income is completely offset by the allocations for the ineligible children, leaving an excess allocation of $25.00. Deduct that allocation from the parents' earned income.	$2,285.00 - 25.00 $2,260.00
From the reduced amount of the parents' earned income, deduct the general income disregard of $20.00. Then deduct earned income exclusions: $65.00 One-half the remainder	$2,260.00 - 20.00 $2,240.00 - 65.00 $2,175.00 ÷ 2 $1,087.50
From that amount, subtract the amount allocated for the parents' needs, i.e., the FBR for a couple ($1,082.00). This balance, $5.50, is deemed to Jackson.	$1,087.50 - 1,082.00 $ 5.50
Jackson has no other income. Apply the $20.00 general income disregard to Jackson's deemed income of $5.50 to calculate his countable unearned income.	$ 5.50 - 20.00 $ (14.50)

SSI compares Jackson's countable income to the appropriate SSI Benefit Level for an individual. Depending on circumstances, the SSI Benefit Level could be Living in the Household of Another rate or the Living with Others rate.

Since the $20.00 general income disregard completely offsets the amount of Jackson's income, Jackson is eligible for SSI.

SSI determines Jackson's SSI monthly benefit amount by subtracting his countable income, including deemed income, of a prior month from the appropriate SSI payment level for the individual for the current month.

Example 4 – Parental Deeming of Resources

Thomas, a 16-year-old with a disability, resides with his parents who are not eligible for SSI. Thomas' parents have a joint savings account of $4,000.00.

Thomas' parents applied for SSI on his behalf.

How will the parents' resources affect Thomas' SSI eligibility?

SSI calculates Thomas' resources as follows:

Parents' countable resources subject to deeming	$4,000.00
SSI resource limit for a couple (2014)	-3,000.00
Value of parents' resources deemed to Thomas	$1,000.00
Value of parents' resources deemed to Thomas	$1,000.00
Thomas' own resources	+ 0.00
Thomas' total countable resources	$1,000.00

Thomas is resource-eligible for SSI. SSI would continue the eligibility determination for Thomas based on Thomas' own and his parents' income as illustrated in the previous examples.

Example 5 – Parental Deeming of Resources

Antonio is 11 years old. His brother Mark, 14, does not have a disability. His parents have resources worth $4,850.00. Antonio has no resources.

Antonio's parents applied for SSI on his behalf.

How will the parents' resources affect Antonio's SSI eligibility?

SSI calculates Antonio's resources as follows:

Parents' countable resources subject to deeming	$4,850.00
SSI resource limit for a couple (2014)	-3,000.00
Value of parents' resources available for deeming	$1,850.00
Value of parent's resources deemed to Mark	0.00
Value of parents' resources deemed to Antonio	$1,850.00
Antonio's own resources	+ 0.00
Antonio's total countable resources	$1,850.00

Mark's deemed resources are $0.00 because SSI does not deem resources for non-disabled siblings. Antonio is resource-eligible for SSI because his countable resources are below the current resource limit of $2,000.00.

SSI would continue the eligibility determination for Antonio based on his own and his parents' income as illustrated in the previous examples.

Example 6 – Parental Deeming of Resources

Jennifer and Joanne are 11-year-old twins with disabilities. Their parents have resources worth $6,200.00. Jennifer has no resources but Joanne has a bank account with a balance of $210.00.

The girls' parents applied for SSI on their behalf.

How will the parents' resources affect Joanne's and Jennifer's SSI eligibility?

SSI calculates the girls' resources as follows:

Parents' countable resources subject to deeming	$6,200.00
SSI resource limit for a couple (2014)	-3,000.00
Value of parents' resources available for deeming	$3,200.00
Value of parent's resources deemed to Jennifer	1,600.00
Jennifer's own resources	+ 0.00
Jennifer's countable resources	$1,600.00
Value of parents' resources deemed to Joanne	$1,600.00
Joanne's own resources	+ 210.00
Joanne's total countable resources	$1,810.00

Their parents' resources available for deeming are divided equally between their disabled children. Jennifer and Joanne are resource-eligible for SSI.

SSI would continue the eligibility determination for Jennifer and Joanne based on their own and their parents' income as illustrated in the previous examples.

Example 7 – Parental Deeming of Resources

Lydia is a 10-year-old with a disability and lives alone with her mother, Jennifer. Jennifer has resources worth $3,680.00. Lydia has no resources.

Lydia's mother applied for SSI on her behalf.

How will Jennifer's resources affect Lydia's SSI eligibility?

SSA calculates Lydia's resources as follows:

Parents' countable resources subject to deeming	$3,680.00
SSI resource limit for an individual (2014)	-2,000.00
Value of Jennifer's resources available for deeming	$1,680.00
Value of Jennifer's resources deemed to Lydia	$1,680.00
Lydia's own resources	+ 0.00
Lydia's total countable resources	$1,680.00

Lydia is resource-eligible for SSI.

SSI would continue the eligibility determination for Lydia based on Lydia's own and her mother's income as illustrated in the previous examples.

SSI Dedicated Account

SSI requires that a representative payee be named for an eligible child who is under 18. When a child is eligible for certain large past-due payments covering more than six months of benefits, the payments must be paid directly into a separate account in a financial institution. This separate account is called a dedicated account because funds in this account may only be used for certain expenses, primarily those related to the child's disability. The dedicated account must be maintained separately from any other savings or checking account set up for the child. SSA monitors the expenditure of the funds from the dedicated account on an annual basis.

A representative payee is allowed to use dedicated account funds for the child's medical treatment and education or job skills training and for any of the following (*if they benefit the child and are related to the child's impairment*):

- Personal needs assistance
- Special equipment
- Housing modification
- Therapy or rehabilitation
- Other items or services SSA determines appropriate such as legal fees incurred by the child in establishing a claim for disabled child's benefits.
- Dedicated accounts may not be used for basic monthly maintenance costs such as food, clothing, or shelter. The regular monthly benefit received for the child should be used for all monthly maintenance costs.

SSA has determined that in emergency situations where the unavailability of dedicated account funds for basic living expenses may result in the child becoming homeless or malnourished, expenditures from the dedicated account may be used if they are otherwise appropriate. The representative payee cannot use dedicated account funds to repay an overpayment.

Note: Under OPWDD's regulations, resources of an individual in an OPWDD-certified residential program cannot be used to pay for medical services if the individual has Medicaid.

Dedicated account rules continue to apply until the depletion of funds or the individual's benefit eligibility terminates. This includes situations where the individual reaches age 18, continues to be eligible and becomes his or her own payee, or when a new payee is appointed. The former payee must return conserved dedicated account funds to SSA for reissuance to the new representative payee or the individual as self payee. SSA will not reissue the conserved dedicated account funds until the new payee has established a new dedicated account.

Continuing Disability Review for Children

The law requires SSA to do a period continuing disability review (CDR) to determine whether a child is still disabled. The CDR must be done at least every three years for recipients under 18 whose conditions are likely to improve and not later than 12 months after birth for babies whose disability is based on low birth weight. SSA may also do a CDR for a recipient under 18 whose condition is not likely to improve.

At the time SSA does a CDR, the representative payee must present evidence that the child is and has been receiving treatment that is considered medically necessary and available for his or her disabling condition. If the child's representative payee refuses to provide such evidence when requested and there is no good cause for the refusal, SSA may suspend payment of benefits to the representative payee and select another representative payee, if it is in the best interest of the child.

Benefits continue in payment status unless there is strong proof that a person's impairment has medically improved and that he or she is able to return to work. The individual can file an appeal if he or she disagrees with the determination. Otherwise, benefits stop 3 months after the beneficiary is notified that his or her disability ended. Benefits for dependents continue as long as the disabled worker continues to be entitled to benefits.

Disability Redetermination for a Child Approaching Age 18

A disability redetermination is required for an individual who was SSI eligible as a child in the month before he or she attained age 18. The redetermination is done during the one-year period beginning on the individual's 18th birthday. SSA uses adult disability rules for the redetermination.

How to Apply for Supplemental Security Income

Making an Appointment

To apply for SSI, an individual or his or her representative makes an appointment with the local SSA office. The appointment can be made in person at the local SSA office or by calling 1-800-772-1213.

Submitting an Application

The applicant or his or her representative must submit a signed application and work with the SSA office to supply all documents needed for determining SSI eligibility (see Application for Supplemental Security Income (SSI) (G-SSA-8000-BK), page 226 for a copy of the application for SSI). Many of the forms needed to apply for SSI are not designed for self-completion. An SSA claims representative conducts the interview and completes the forms with information provided by the applicant.

Protective Filing Date

If the individual or his or her representative is unable to submit a completed SSI application immediately, he or she should contact Social Security to establish a

protective filing date[3] for the individual's SSI application. Generally, SSA will require the following information about the applicant:

- Name
- Social Security number
- Birth date
- Citizenship
- Income
- Resources

When a protective filing is required, SSA sends a letter to the individual confirming the appointment and uses the protective filing date as the SSI application date as long as the completed application is filed within 60 days.

Effective Dates

The SSI benefit will be effective the month after the application is filed or the month after the first month the individual is eligible for SSI, whichever is later.

Notice of Award

Once the SSI application is approved, SSA will send an award notice - SSI Payment Decision Notice (Form SSA-8025), which will include:

- The monthly payment amount
- The SSI claim number
- The effective date of the benefit

If the individual or his or her representative discovers incorrect information contained in the award notice, he or she should immediately contact SSA.

If the individual or his or her representative has not received a decision within 90-120 days, he or she should contact SSA to determine the reason for the delay of the application.

Agency Representative Payee Application

If the agency files to receive benefits on behalf of an individual (become a representative payee), SSA-11 BK (Request to be Selected as a Payee) must be completed. A copy of this application is included in the Additional Resources section (see Request to be Selected as Payee (SSA-11-BK), page 249). For a more detailed discussion about the representative payee program, see information beginning on page 97.

[3] This action, which puts the Social Security Administration on notice that an individual intends to file for benefits even though an application is not yet complete, may benefit the individual by enabling him or her to receive benefits retroactive to the date when the intention to file is announced (protective filing date) rather than the date when the completed application is actually filed.

Capability

In response to the Agency's request to be selected as a payee, SSA may request that a physician or medical officer complete a Physician's/Medical Officer's Statement of Patient's Capability to Manage Benefits (Form SSA-787). See page 259 for a copy of this form. Based on this medical evidence, SSA determines whether an individual is capable of managing his or her benefits (SSI funds).

Denial of Application

If the application has been denied, an individual, representative, or the agency has the right to appeal the decision made about his or her eligibility or payment amount. The SSI notice will advise the individual of the further steps and timing of the appeal process (information on appeals can be found beginning on page 103).

Documentation for SSI Application

The following is a list of some of the documents that SSA may request when applying for SSI. The individual will not need to present *all* of the documents; sometimes one document can substitute for another and documents other than those listed here may be required. SSA will tell the applicant what he or she needs and what other documents are acceptable. Documents presented to SSA must be originals. If the individual does not have an original document, SSA can accept a certified copy from the office that issued the original document, but photocopies are not acceptable. SSA will return the original documents to the applicant.

SSA may ask the individual to present the following documents:

Social Security Information

- Social Security card or number

Proof of Age

- Birth record or religious birth record
- Other documents showing individual's age or date of birth

Citizen or Non-Citizen Status Record

- Birth certificate showing that individual was born in the U.S.
- Religious record of birth or baptism showing the place of birth in the U.S
- Naturalization certificate
- U.S. passport
- Certificate of citizenship
- Current non-citizen immigration document such as:
    - Permanent Resident Card (I-551)
    - Arrival/Departure Record (I-94)
- If an individual is a non-citizen who has served in the U.S. Armed Forces, he or she may need his or her military discharge papers (DD-214)

Proof of Income

- Earned income:
  - Payroll stubs
  - If self-employed, a tax return for the last tax year, and work expenses
- Unearned income:
  - Any records which show how much the individual receives (e.g., award letters, bank statements, court orders), how often, and the source of the payment

Proof of Resources

- Bank statement(s) for all checking and savings accounts
- Deed or tax appraisal statement for all property the individual owns besides the house he or she lives in
- Life or disability insurance policies, burial contracts, plots, etc.
- Certificates of deposit, stocks, or bonds
- Titles or registrations for vehicles like cars, trucks, motorcycles, boats, campers, etc.
- Trust documents

Proof of Living Arrangement

If the individual is not residing in a congregate care facility or certified living arrangement, SSA may ask to see some of the following documents:

- Lease or rent receipt
- Names, dates of births, medical assistance cards or Social Security numbers for all household members
- Deed or property tax bill
- Information about household costs, food, utilities, etc.

Medical Information (Blind or Disabled Individuals)

- Medical reports
- Psychological reports
- Clinical reports
- Names, addresses, and telephone numbers of doctors, hospitals and other providers of medical services and the approximate dates of treatment

Work History

- Job titles
- Types of businesses
- Names of employers
- Dates worked
- Hours worked per day and hours worked per week
- Days worked per week, and rates of pay for work for the 15 years before the individual became unable to work because of illnesses, injuries, or conditions
- Description of job duties for the type of work performed

Other Sources of Information

If an individual is applying as a disabled child, or on behalf of a disabled child, SSA needs the names, addresses, and telephone numbers of people (teachers, caregivers) who can provide information about how the disabled child's medical condition affects his or her day-to-day activities. In addition, a copy of an Individualized Education Plan (IEP) from his or her school is required.

Representative Payee Program

A representative payee (RP) is a person, agency, organization, or institution selected by SSA to manage an individual's payments when the individual is physically or mentally unable to do so. Before appointing a representative payee, SSA evaluates medical evidence and other information about the SSI beneficiary's ability to manage his or her SSI payments.

SSA requires that a representative payee be named for an individual who is under the age of 18 or is a legally incompetent adult, or anyone whom SSA determines to be incapable of managing or directing the management of his or her funds.

SSA may appoint any of the following as representative payee for an individual in the following order of preference:

- A person, other than a convicted felon, who is concerned with the individual's welfare (usually a spouse, close relative, guardian, or friend)
- The director of a residential institution, such as a nursing home or health care provider, including the director of a voluntary agency
- A public or nonprofit agency or financial organization

Duties of a Representative Payee

The representative payee is responsible for:

- Using SSI payments for the individual's current needs or saving for his or her future needs. A beneficiary's current needs primarily include food, clothing, shelter, utilities, medical care and insurance, personal hygiene, education, and rehabilitation expenses.

  If the beneficiary resides in a residential program that is certified by OPWDD, his or her funds must be handled in accordance with OPWDD regulations in addition to SSA requirements. Under OPWDD regulations, the individual's funds are generally not available to cover medical care, rehabilitation expenses and other items or services that the residential provider is required to provide for the individual.

- Maintaining a continuing concern for the personal welfare of the beneficiary. If the beneficiary is not living with the representative payee, this concern may be

shown by visits, consultations on the beneficiary's condition and current needs, and planning for the future of the beneficiary.

- Reporting changes in the individual's circumstances to SSA (see the Reporting Responsibilities part of this section)

- Providing a simple accounting to SSA and to the individual about how the money was spent (SSA usually requests an accounting each year)

- Responding on the individual's behalf to any SSA requests for action or information (common requests are the SSI redetermination of eligibility and the request for a continuing disability review)

The representative payee's authority is limited to matters between the individual and SSA. The representative payee may, at any time, request that SSA change or terminate the payee arrangement. Following such a request, SSA will investigate the situation and make a decision regarding a successor payee.

When an individual moves from one residential program to a residential program operated by a new agency, the individual's representative payee will change. The agency operating the new residential program is required under OPWDD regulations to file to become representative payee within three business days after the individual's placement.

During the transition from one payee to another, an individual's conserved SSI monies must be returned to SSA in order to be reissued to the new payee. If specifically permitted by SSA (permission must be in writing if the individual resides in an OPWDD certified living arrangement), the "old" payee may forward the full balance directly to the new payee. Voluntary agencies must follow OPWDD regulations regarding the handling of personal allowance.

As a representative payee, the agency is responsible for keeping records and reporting on how it spends the benefits by completing a Representative Payee Report (Form SSA-623, SSA-6230 or SSA-6233). The appropriate form is mailed to the representative payee about once a year. SSA may randomly do a brief onsite review of a representative payee agency. The objective of such reviews is to ensure that the agency's performance as the payee conforms to SSA policies.

Agency representative payees who serve 50 or more individuals are subject to monitor reviews. Monitor reviews are, in essence, the same as onsite reviews, but since agency representative payees are not state mental institutions, SSA does not use the term "onsite reviews". Unlike state mental institutions that participate in SSA onsite reviews, agency representative payees are responsible for completing the annual representative payee review forms. In addition, SSA may randomly do a brief review of agency representative payees.

Further information regarding the duties of a representative payee can be found at the Social Security website, http://www.ssa.gov/payee/index.htm. Staff of agencies that serve as representative payees should review The Guide for Organizational Representative Payees.

Overpayments and Underpayments

An underpayment occurs when an individual does not receive his or her monthly benefit or is not paid the amount to which he or she is entitled. Careful monitoring of the SSI benefit payments and knowledge of the individual's payment level can minimize underpayments. The SSI payment levels are available on the OPWDD website at www.opwdd.ny.gov and on page 225 of this guide, 2014 SSI Benefit Levels.
An overpayment is a payment in a higher amount than was due, or a payment made when none was due.

An SSI beneficiary and/or a representative payee receiving SSI on behalf of a beneficiary may be equally liable for repayment of any overpayment received as follows:

- The beneficiary is liable if he or she received the benefit of the monies
- The representative payee is personally liable if he or she was at fault in creating the overpayment or did not apply the funds for the beneficiary's use and benefit

The agency, SSA, or both, will usually discover underpayments or overpayments when redetermining an individual's eligibility and payment amount.

Causes of Overpayment and Underpayment

Incorrect SSI payments may result from any of the following situations or not reporting changes to SSA timely:

- The individual's income, earned or unearned, was different from the amount that was estimated
- The individual's living situation changed
- The individual's marital status changed
- SSA incorrectly figured the individual's payments because of incorrect or incomplete information
- The individual had more resources than the limit allowed by the SSI program
- The individual was no longer disabled but continued to receive payments

Notice of Underpayment or Overpayment

SSA sends a written notice to the SSI recipient when an underpayment or overpayment of benefits occurs. The notice states the amount in question, how and when the overpayment or underpayment occurred, and the individual's right to appeal the decision. For more about the appeals process, see below.

Request for Refunds in Case of Overpayment

In the case of an overpayment, SSA sends a notice asking for a full refund within 30 days. If the individual is currently receiving payments, the notice will contain the following information:

- A proposal to withhold the overpaid amount at the rate of 10% of the individual's total monthly income and the month the proposed withholding would begin
- A full explanation of the individual's appeal rights and how to appeal the decision
- A explanation of how the individual can ask to have the overpayment reviewed and waived

If there is no response to the overpayment notice within 30 days, there will be an automatic check adjustment of 10% 60 days after the date of the automated or manual overpayment notice.

Individuals Liable for Refunding Overpayments

SSA may attempt to recover an overpayment only from the following individuals:

- The overpaid individual
- The representative payee
- The spouse of the overpaid individual, but only for that part of the overpayment period when the spouse was a member of the eligible couple
- Under certain circumstances, the sponsor of an non-citizen individual
- The estate (or distributees) of any of the above

When the SSI recipient is paid through a representative payee, both the individual and the representative payee may be responsible for repayment.

- The individual is responsible to the extent that the incorrect payments were expended on him or her. Funds conserved by a representative payee to whom the individual does not have direct access are not considered as having been expended on the individual.

- If the incorrect payments were expended on the individual and the representative payee is without fault in connection with the overpayment, the individual is solely responsible for repayment.

- The representative payee is individually responsible for repayment if the incorrect payments were not used for the support and maintenance of the individual.

- The individual and representative payee are both liable when the incorrect payments have been expended on the individual and the representative payee is at fault.

A representative payee's use of an individual's properly conserved funds to repay an overpayment is appropriate only when:

- The overpaid individual is liable for the repayment of the overpayment
- SSA has not waived recovery of the overpayment

Request for Waiver of Recovery of Overpayment

When an SSI recipient receives more SSI than he or she was due, the Social Security Administration sends the recipient and the representative payee, if applicable, a notice of overpayment. The notice contains details of the amount that was overpaid, a request for repayment, and a plan for recovery of the overpayment from future benefits if the repayment is not immediately made in full. Depending on circumstances, the person could pay it back, request reconsideration, or file a request for a waiver of overpayment. If the recipient or representative payee believes that the overpayment determination was in error, he or she can request a hearing. The notice also contains information about how the determination of an overpayment can be appealed.

Additional information is covered in a separate section on appeals in this manual.

Some overpayments are not pursued by the Social Security Administration because they are deemed to impede effective or efficient administration. In these situations, the cost associated with pursuing and recovering the overpayment exceeds the actual amount of the overpayment. The recovery of the overpayment is not pursued only if the recipient is found to be without fault regarding the overpayment.

Recipients are presumed to be without fault if the overpayment is $30.00 or less. For amounts over $30.00 and up to $500.00, the recipient is required to request a waiver of overpayment or reconsideration if he or she would like the Social Security Administration not to pursue the overpayment. In these situations involving the higher amounts of money, the Social Security Administration makes a determination regarding the recipient’s fault. If the person is found to be without fault, then the recovery is discontinued.

For SSI purposes, fault is:

- A willful misstatement
- A concealment of facts or fraud that directly or indirectly caused the overpayment
- A knowing acceptance of an incorrect payment

The individual can request a waiver of the overpayment at any time during the repayment process. For example, when an individual who is repaying an SSI overpayment is placed in a certified residential setting, a request may be made to SSA for a waiver of the remaining amount. SSA uses the date that the written request is received in the SSA office as the effective date of the waiver. A request for waiver stops the recovery of overpayment effective the month the waiver is entered into the

SSA computer records. Recovery will not begin again until SSA makes an adverse waiver determination and the appeal period expires.

Non-Citizens and SSI

In general, most non-US citizens residing in the United States must meet both the following requirements to be eligible for SSI:

- The non-citizen must be in a qualified alien category
- The non-citizen must meet an exception condition for qualified aliens

A person is a qualified alien if he or she meets one of the following conditions:

- Lawfully admitted for permanent residence (LAPR) in the U.S.
- Granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act (INA) as in effect prior to April 1, 1980
- Paroled into the U.S. under section 212(d)(5) of the INA for a period of at least 1 year
- A refugee admitted to the U.S. under section 207 of the INA
- Granted asylum under section 208 of the INA
- An alien whose deportation is being withheld under section 243(h) of the INA as in effect prior to 4/1/97, or whose removal has been withheld under section 241(b)(3) of the INA
- An alien who is a Cuban/Haitian entrant under one of the four categories in section 501(e) of the Refugee Education Assistance Act of 1980
- Under certain circumstances, an alien who has been subjected to battery or extreme cruelty, or whose child or parent has been subjected to battery or extreme cruelty, can be determined to be a qualified alien based on those circumstances

Qualified alien status alone is not sufficient to establish eligibility for SSI. In addition to being a qualified alien, the individual must meet one of the following additional requirements in order to be found eligible:

- Was receiving SSI on 8/22/96 and is lawfully residing in the U.S. (grandfathered qualified alien)

- Lawfully admitted permanent resident with 40 Qualifying Quarters of earnings (NOTE: There is a five-year ban to eligibility for individuals who entered the U.S. on 8/22/96 or later unless certain exceptions apply)

- Veteran or active duty member of the U.S. Armed Forces, a spouse or dependent child of a veteran or active duty member

- Lawfully residing in the U.S. on 8/22/96 and is blind or disabled

- Alien in one of the five designated immigrant status classifications identified below, and the status was granted within seven years of the date he or she filed for SSI:

    - Refugee under section 207 of the INA

    - Asylee under section 208 of the INA

    - Alien whose deportation is being withheld under section 243(h) of the INA or whose removal has been withheld under section 241(b)(3) of the INA

    - Cuban/Haitian entrant under one of the four categories in Section 501(e) of the Refugee Education and Assistance Act of 1980

    - "Amerasian immigrant" under section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 ("Amerasian immigrants" are, by definition, LAPR, thus they are qualified immigrants. If an individual is an "Amerasian immigrant" and meets no other condition permitting eligibility, he or she is potentially eligible for seven years, beginning with the date "Amerasian immigrant" status was granted. Amerasians who enter as non-immigrants, such as foreign students pursuing studies in the U.S., cannot be qualified aliens.

Federal legislation enacted between 1996 and 1998 changed the alien eligibility requirements for individuals who may be eligible for SSI to include the following:

- Citizens or nationals of the U.S.
- Certain American Indians born outside the U.S.
- Qualified aliens, but only under certain circumstances
- Certain nonqualified aliens who were receiving SSI on 8/22/96

Appealing an Adverse Decision

If an individual disagrees with an initial Social Security or SSI determination or decision, he or she may appeal the decision.

Levels of Administrative Review

Appeal of an adverse decision regarding SSI consists of the following levels of administrative review.

Reconsideration

Reconsideration is a complete review of a claim by SSA staff who did not take part in the first decision. A case review or an informal or formal conference may be requested. In a case review, SSA will look at the case without meeting with the individual. In informal and formal conferences, the individual and his or her representative may participate and present witnesses. A formal conference also gives the individual the opportunity to question witnesses and gives SSA the opportunity to require witnesses to appear.

A reconsideration request must be made in writing within 60 days of receipt of the notice of determination. SSA will assume the determination was received within five days of the notice date.

Note: SSA no longer uses the Reconsideration step for disability determinations made in New York State, however, Reconsideration may be requested in other adverse post-eligibility issues.

Administrative Law Judge Hearing

If the applicant disagrees with a reconsideration decision (if applicable), a hearing may be requested. An administrative law judge who had no part in the initial decision or the reconsideration of the case will conduct the hearing.

Appeals Council Review

If the applicant disagrees with a hearing decision, he or she may ask for a review by Social Security's Appeals Council. The Appeals Council considers all requests for review, but it may deny a request if it believes the hearing decision was correct. If the Appeals Council decides to review the case, it will either decide the case itself or return it to an administrative law judge for further review.

Federal Court Review

If the individual disagrees with the Appeals Council's decision or if the Appeals Council decides not to review the case, the individual may file a lawsuit in a federal district court. The letter SSA sends the individual about the Appeals Council's action also will tell him or her how to ask a court to look at the case.

Timeframe for Requesting an Appeal

An individual has 60 days from the date he or she receives a Social Security or SSI decision letter to request an appeal. If the last day of the 60-day window falls on a Saturday, Sunday, or national holiday, the next business day is considered the last day of the window. SSA will assume the individual received the decision letter within five days after the date on the letter, unless the individual can prove that he or she received it later.

Format for Requesting an Appeal

A request for an appeal must be in writing, either by using an SSA appeal form (available by request from SSA) or by sending SSA a signed letter stating that the individual wishes to appeal the decision and including his or her Social Security number. If the individual does not appeal within 60 days, he or she may lose the right to do so. In that case, the last SSA decision is final. If the person has good reason for not appealing within the time limit, he or she may request more time. The individual must request more time from the SSA in writing, and must state the reason for the delay.

Requesting Continued Benefits during the Appeal Process

An individual may request that SSA continue to pay his or her benefits while SSA is making a decision on an appeal if the individual is appealing a decision that he or she can no longer get Social Security disability benefits because his or her medical condition is not disabling. In order for benefits to continue, the request must be made within 10 days of the date of receipt of the letter from SSA informing the individual of the decision. If the individual's appeal is denied, he or she may have to pay back any money that he or she was not eligible to receive.

Repayment Process if the Appeal to the Administrative Law Judge is Denied

If an appeal is denied, the individual and his or her Representative Payee (if applicable) will receive a notice of the Administrative Law Judge's decision. If repayment of SSA benefits is required, individuals may repay in a lump sum or arrange with SSA to repay in installments (at least $10 per week) over a 12-month period. If repayment within 12 months is not possible, repayment may be spread over 36 months. Alternatively, if the individual is receiving other benefits from SSA, he or she may choose to have their benefits reduced by the amount of the repayment obligation until the funds are repaid.

Process for Additional Appeals

An individual or appointed representative must request an appeal in writing within 60 days of the date the notice was received. The SSI notice will advise the individual of the period within which he or she must request further review. If the appeal is filed within ten days, SSI benefits may continue at the same amount until SSA makes a determination on the appeal. The notice will also advise if an individual is entitled to continued benefits.

If the individual does not request review within the required time period, he or she may lose the right to further review unless he or she can show good cause for failure to make a timely request for review.

When an individual disagrees with the initial determination, he or she may request reconsideration by completing:

- Request for Reconsideration (Form SSA-561-U2) (page 283), or
- Request for Reconsideration - Disability Cessation Appeal – Right to Appear (Form SSA-789-U4) (page 287)

Note: The Social Security Administration has published notification that changes will be made to the disability review and appeal processes. Information concerning the changes will be available at www.ssa.gov or www.socialsecurity.gov. Because the changes have not been finalized, we are unable to provide the information.

Additional Information about SSI

Information about SSI is available 24 hours a day, including weekends and holidays, at Social Security's toll-free telephone number, 1-800-772-1213. A service representative is available between the hours of 7 a.m. to 7 p.m. on business days. Lines are busiest early in the week and early in the month. The caller should have the individual's Social Security number handy when calling.

People who are deaf or hard of hearing may call SSA's toll-free TTY number, 1-800-325-0778, between 7 a.m. and 7 p.m. on business days.

All calls to the Social Security Administration, whether made to the toll-free numbers or to an office, are treated as confidential.

The following are some SSA publications that may be helpful in understanding SSI:

- What You Need to Know When You Get SSI – SSA Publication Number 05-11011
- A Guide to SSI For Groups and Organizations – SSA Publication Number 05-11015
- Understanding Supplemental Security Income – SSA Publication Number 17-008
- Benefits for Children with Disabilities – SSA Publication Number 05-10026
- A Guide for Representative Payees – SSA Publication Number 05-10076
- Guide for Organizational Representative Payees - SSA Publication Number 05-10061

The publications can be downloaded from the from the Social Security Administration internet homepage, which is located at www.ssa.gov or www.socialsecurity.gov.

Social Security Benefits

Definition

Social Security benefits are payments made to covered individuals based on contributions a worker has made to the Social Security trust fund. The Federal Insurance Contributions Act (FICA) mandates withholding Social Security contributions from a worker's paycheck. The Social Security Administration (SSA) is responsible for administering Social Security benefits.

Difference between SSI and Social Security Benefits

Supplemental Security Income (SSI) differs from the Social Security benefits discussed in this section. Unlike SSI, Social Security benefits are not needs-based. Social Security benefits are entitlements based on a worker's contributions; therefore, there are no income or resource eligibility factors associated with collecting Social Security benefits. The amount that a recipient is paid is based on the earnings of the specific worker. Information on SSI can be found in the preceding section.

Types of Social Security Benefits

The types of Social Security benefits that a worker or certain members of the worker's family may receive are:

- Social Security Disability Insurance (SSDI)
- Social Security Retirement
- Social Security Survivors

Filing for Social Security Benefits

An individual should file for Social Security benefits as soon as it is believed that he or she is eligible (see SSA Benefit Eligibility Chart, page 295 for SSA benefits eligibility information). There is no waiting period to file for benefits; however, there is a five-month waiting period for a disabled worker to begin receiving Social Security Disability Insurance (SSDI) benefits. SSDI benefits are sometimes referred to as SSD or SSA.

Additional Information about Social Security Benefits

Additional information about Social Security benefits is available on the SSA website: www.ssa.gov or www.socialsecurity.gov.

Eligibility for Social Security Benefits

An individual may be entitled to Social Security benefits based on his or her own work record or based on a spouse's or parent's work record. The benefit amounts will vary depending on a worker's contributions and there is a maximum amount of benefits payable on a worker's record.

Section 8: Social Security Benefits

Note: Disabled adult children may be eligible for Social Security benefits on a parent's work record; therefore, it is important to determine whether the person's parents are working, retired, disabled or deceased, and to take action to apply for benefits as soon as possible after the parent(s) stop(s) working.

Social Security Retirement Benefits

A person may qualify for Social Security Retirement benefits upon retiring from work. He or she can choose to retire at full retirement age and receive full Social Security Retirement benefits, or retire as early as age 62 and receive reduced benefits. Most people approaching retirement now cannot receive full retirement benefits until after age 66. The full retirement age will gradually increase to 67. Delaying application until full retirement age based on the year of the applicant's birth allows him or her to collect full benefits. Information about benefit levels and ages for collecting Social Security retirement benefits can be found on the SSA website at www.ssa.gov or www.socialsecurity.gov.

The amount of an insured worker's retirement benefits is based on his or her lifetime earnings. The worker's actual earnings are indexed to reflect changes in average wages over the years the insured person worked.

Social Security Survivor Benefits

Social Security Survivors benefits are available to certain family members of a deceased worker who earned enough credits while working to be insured**.**

Social Security Survivors benefits can be paid to:

- A widow or widower - full benefits at full retirement age, or reduced benefits as early as age 60
- A disabled widow or widower - as early as age 50
- A widow or widower of any age if he or she takes care of the deceased's child who is under age 16 or disabled and receiving Social Security benefits
- Unmarried children under 18 or up to age 19 if they are attending high school full time (under certain circumstances, benefits can be paid to stepchildren, grandchildren, or adopted children)
- Children of any age who were disabled before age 22 and remain disabled
- Dependent parents age 62 or older

Social Security Disability Insurance

Social Security Disability Insurance (SSDI) provides income benefits to disabled or blind individuals who meet all of the following criteria:

- The person has worked and paid Social Security taxes long enough to be covered under Social Security insurance (the number of credits needed for disability benefits depends on the individual's age at the time he or she became disabled)
- He or she has paid Social Security taxes in recent years

- He or she is considered medically disabled or blind
- He or she is either not working or is working and earning less than the Substantial Gainful Activity (SGA) level

Definition of Disability

A person is generally considered disabled if he or she cannot do work done before becoming disabled or blind and cannot adjust to other work due to his or her medical condition. The SSA defines disability as the inability to engage in any substantial gainful activity because of a medically determinable physical or mental impairment that either:

- Has lasted, or is expected to last, at least one year; or
- Is expected to result in death

A disabled adult child may qualify for disability benefits under a worker's record when the worker begins receiving Social Security benefits, retires, or dies.

Substantial Gainful Activity

A person is generally considered disabled if he or she cannot do work he or she did before becoming disabled or blind and cannot adjust to other work due to his or her medical condition. SSA evaluates the work activity of the person claiming or receiving disability benefits under SSDI. SSA uses earnings guidelines to determine whether the individual's work activity is considered Substantial Gainful Activity (SGA) and whether the individual is disabled.

SGA is the performance of significant and productive physical or mental work for pay or profit. A dollar amount is designated as the SGA level. Individuals whose monthly earnings average more than the SGA level are deemed to be engaged in substantial gainful activity in the absence of evidence to the contrary. A person whose monthly earnings average below the SGA level is presumed not to be engaged in SGA. The SGA level is higher for people who are blind.

Social Security Benefits for Children

Minor children may qualify to receive benefits on a parent's work record when the parent retires, is disabled, or dies. An eligible child can be a biological child, adopted child or stepchild. A dependent grandchild may also qualify.

To receive benefits, the child must:

- Be unmarried
- Be under age 18
- Be 18-19 years old and a full-time student (no higher than grade 12)
- Be 18 or older and disabled from a disability that started before age 22 (see below for information regarding Social Security benefits for a Disabled Adult Child)

If a child works while receiving benefits, the same earnings limits apply to him or her as apply to the worker. A child's earnings affect only his or her own benefits. They do not affect the worker's benefits or those of any other beneficiaries on the worker's record. If the worker works while receiving his or her benefits, his or her earnings may impact the benefits of all beneficiaries receiving on the worker's record.

Benefits paid to a minor child are "derivative" benefits based on a parent's work record. While the child may be disabled, benefits paid to children who are under the age limits listed above are not disability benefits. Normally, benefits stop when children reach age 18, however, if the child is still a full-time student at a secondary (or elementary) school at age 18, benefits will continue until the child graduates or until two months after the child becomes age 19, whichever is first. If a child is disabled and turns 18 (or 19 if he or she is still in elementary or secondary school), a disability determination is required in order to qualify him or her for Disabled Adult Child benefits.

Social Security Benefits for a Disabled Adult Child

An unmarried child at least 18 years old with a disability that started before age 22 may be eligible to receive Social Security benefits on a parent's work record when that parent begins receiving SSDI or Retirement benefits or dies. These are Disabled Adult Child (DAC) benefits. If an individual is already receiving Social Security benefits when he or she turns 18, a disability determination by SSA is required in order for him or her to collect benefits as a DAC.

The marriage of a DAC beneficiary to someone who is not receiving Social Security disability benefits causes termination of DAC benefits. If the DAC beneficiary marries someone who is receiving Social Security disability benefits at the time of the marriage, the individual's DAC benefits will not terminate because of the marriage.

A person who loses a DAC benefit when he or she marries may be re-entitled to the DAC benefit if the marriage is annulled or voided. An annulled or voided marriage is legally nonexistent under state law, with or without a judicial decree. The parties to a void or annulled marriage are considered never to have been husband and wife. A person who loses a DAC benefit when he or she marries would not be re-entitled to the DAC benefit if the marriage were to end by death or divorce.

An individual's DAC benefit is independent of any SSDI or DAC benefits received by his or her spouse. Therefore, Social Security benefits paid to a DAC beneficiary do not end if/when his or her spouse's SSDI or DAC benefits end.

DAC benefits end if the individual if Social Security determines that the individual is no longer disabled.

Questions about an individual's eligibility for continued DAC benefits or for re-entitlement should be directed to the local Social Security office.

How to Apply for Social Security Benefits

There are four ways to apply for Social Security benefits:

1. Online at www.ssa.gov or www.socialsecurity.gov

2. By phone at 1-800-772-1213

3. By mail (the specific local office can be located by zip code at www.ssa.gov or www.socialsecurity.gov)

4. In person (the specific local office can be located by zip code at www.ssa.gov or www.socialsecurity.gov)

About the Interview Process

In order to begin the application process if not applying online, it is necessary to make an appointment for a disability claims interview by calling SSA's toll free number (1-800-772-1213) to make an appointment. Application for DAC benefits cannot be made online.

The disability claims interview lasts about one hour. When an interview is scheduled, SSA will mail a Disability Starter Kit to the applicant. The Disability Starter Kit will help the applicant prepare for the disability claims interview. The Disability Starter Kit is also available online at www.ssa.gov or www.socialsecurity.gov.

To prepare for the interview, the Disability Report, Medical and Job Worksheet, and the Disability Checklist included in the kit should be completed in advance. Copies of these forms can be found in the Additional Resources section (Disability Report – Adult (SSA-3368-BK), page 296, Medical and Job Worksheet – Adult (SSA-3381), page 313, and Checklist – Adult Disability Interview, page 315).

Information Required about the Applicant

Regardless of the type of Social Security benefit applied for, the applicant should be prepared to provide the following information about him or herself:

- Name, gender, Social Security number
- Date and place of birth
- Relationship to the worker on whose work record the applicant is applying
- Birth or baptismal certificate
- Marital status
- Citizenship status
- Whether the applicant has a legal guardian
- Whether he or she has earned social security credits under another country's social security system
- Whether he or she has had earnings in all years since 1978
- A summary of where he or she has worked and the kind of work done

- The name(s) of his or her employer(s) or information about his or her self-employment and the amount of earning for the current year and last year
- A copy of the most recent W-2 Form (Wage and Tax Statement) or, if self-employed, his or her federal tax return for the past year
- Whether he or she received or expects to receive any money from an employer since the date he or she became unable to work
- Whether he or she has ever worked for the railroad industry
- Dates of service for any active military service prior to 1968 and any benefits he or she has ever been eligible to receive from a military or civilian agency
- Whether he or she qualifies for or expects to receive a pension or annuity based on his or her own employment with the federal government of the United States or one of its states or local subdivisions
- Whether the applicant has ever been convicted of a felony
- Whether the applicant, age 13 or older, has any unsatisfied felony warrants for arrest or unsatisfied federal or state warrants for arrest for violations of conditions of parole or probation

In addition, for disability benefits, the applicant must supply the following:

- Names, addresses and phone numbers of the doctors, caseworkers, hospitals and clinics that have provided treatment and dates of the visits
- Name(s) and dosage(s) of all medicine he or she takes
- The date he or she became unable to work because of illnesses, injuries or conditions
- Whether he or she is still unable to work
- Medical records already in his or her possession from doctors, therapists, hospitals, clinics and caseworkers
- Laboratory and test results
- Whether he or she has filed or intends to file for worker's compensation or any public disability benefits
- For disability benefits for adult children disabled before age 22, forms SSA-3368 and SSA-827 that describe medical condition and authorize disclosure of information to SSA (see Disability Report – Adult (SSA-3368), page 296 and Authorization to Disclose Information to the Social Security Administration (SSA) (SSA-827), page 311)

In addition to demographic and medical information where applicable, an applicant for Social Security benefits should also be prepared to provide information about his or her parent(s) and/or spouse (current and any former) and his or her work record or that of the worker on whose record the applicant is applying. The following are examples of information SSA may ask for:

Information that may be Required about the Applicant's Parents, Spouse or Work Record

Parental Information

- Parents' names, dates of birth and social security numbers
- Whether the applicant has a parent who was dependent on the worker for half of his or her support at the time the applicant became disabled (if applicable)
- If the applicant is the worker's stepchild, the date the worker and the applicant's parents were married
- Whether the worker is the applicant's natural or adoptive parent
- Date of adoption if adopted by the worker
- Whether the applicant has been adopted by someone other than the worker

Spousal Information

- Spouse's name, date of birth (or age), and social security number (if known) of current and any former spouses
- Dates and places of all marriages and, for marriages that have ended, how and when they ended
- Whether the applicant's spouse has ever worked for the railroad industry

Information about an Applicant's Children

- Names of any unmarried children under 18, ages 18-19 and in secondary school, or disabled before age 22
- Whether the applicant has or had a child under age three living with him or her during a calendar year when he or she had no earnings

Information about a Deceased Worker:

- The worker's date and place of death
- The state or foreign country of the worker's fixed permanent residence at the time of death
- Whether the worker was unable to work because of illnesses, injuries or conditions at any time during the 14 months before his or her death (if "Yes", SSA will also ask for the date he or she became unable to work)
- Whether the worker was in the active military service before 1968 or ever worked for the railroad industry (if so, SSA will ask for the dates of service and whether he or she ever received a pension from a military, federal or civilian agency)
- Whether the worker earned Social Security credits under another country's social security system
- Whether the worker was employed or self-employed in all years from 1978 through last year
- How much the worker earned in the year of death and the year before death
- Whether the worker ever filed for Social Security benefits, Medicare or Supplemental Security Income (if so, SSA will also ask on whose Social Security record he or she applied)
- Whether the applicant was living with the worker at the time of death

SSA accepts photocopies of W-2 forms, self-employment tax returns or medical documents, but must see the original of most other documents, such as a birth certificate (SSA will return original documents to the applicant).

When SSA makes a decision on an application, they send a letter to the beneficiary indicating whether the application has been approved or denied. If it is approved, SSA will include a claim number, which is the Social Security number of the worker with one of the following suffixes:

- A = Self
- B = Spouse
- C = Child (includes DAC)
- D = Widow/Widower

Determination of Benefits Process

It can take three to five months to process an application for disability benefits. When a decision is reached on the case, SSA will send the applicant a letter. If the application is approved, the letter will indicate the amount of the benefit and when the payments will start. If the application is not approved, the letter will explain why and tell the applicant how to appeal the decision if he or she does not agree with it.

When Benefits are Paid

Social Security benefits are paid to either the person or his or her representative payee by check or direct deposit. SSA strongly encourages direct deposit.

The day of the month that an individual receives his or her benefit check is dependent on the date of birth of the person (worker) on whose work record the benefit is paid. The following chart details what day each month a check or the direct deposit is made will be received:

Worker's Birth Date	Monthly Payment Date
1st to the 10th	2nd Wednesday
11th to the 20th	3rd Wednesday
21st to the 31st	4th Wednesday

People who have been in receipt of Social Security benefits from any time earlier than May 1997 receive their benefit payments on or around the 3rd of the month. People who are Medicare buy-in eligible receive their benefits on the 3rd of the month. Individuals who receive both SSI and SSA benefits receive two separate payments around the 1st and the 3rd of the month, respectively.

Limits to Replacement Social Security Cards

A person can replace his or her Social Security card if it is lost or stolen. There is a limit of three replacement cards issued to an individual in one year and a total of ten during a lifetime. Legal name changes and changes in immigration status that require card

updates may not count toward these limits. Limits may also not apply if the individual can prove that the card is needed to prevent a significant hardship.

Appealing an Adverse Decision

If an individual disagrees with an initial Social Security or SSI determination or decision, he or she may request an appeal. The appeal consists of several levels of administrative review as noted below.

Levels of Administrative Review

Reconsideration

Complete review of a claim by SSA staff who did not take part in the first decision. A case review or an informal or formal conference may be requested. In a case review, SSA will look at the case without meeting with the individual. In informal and formal conferences, the individual and his or her representative may participate and present witnesses. A formal conference also gives the individual the opportunity to question witnesses and gives SSA the opportunity to require witnesses to appear.

Note: SSA no longer uses the Reconsideration step for disability determinations made in New York State, however, Reconsideration may be requested in other adverse post-eligibility issues.

Administrative Law Judge Hearing

If the applicant disagrees with an initial determination or a reconsideration decision (if applicable), a hearing may be requested. An administrative law judge who had no part in the initial decision or the reconsideration of the case will conduct the hearing.

Appeals Council Review

If the applicant disagrees with a hearing decision, he or she may ask for a review by Social Security's Appeals Council. The Appeals Council considers all requests for review, but it may deny a request if it believes the hearing decision was correct. If the Appeals Council decides to review the case, it will either decide the case itself or return it to an administrative law judge for further review.

Federal Court Review

If the individual disagrees with the Appeals Council's decision or if the Appeals Council decides not to review the case, the individual may file a lawsuit in a federal district court. The letter SSA sends the individual about the Appeals Council's action also will tell him or her how to ask a court to look at the case.

Timeframe for Requesting an Appeal

An individual has 60 days from the date he or she receives a Social Security or SSI decision letter to request an appeal. If the last day of the 60-day window falls on a Saturday, Sunday, or national holiday, the next business day is considered the last day of the window. SSA will assume the individual received the decision letter within five

days after the date on the letter, unless the individual can prove that he or she received it later.

Format for Requesting an Appeal

A request for an appeal must be in writing, either by using an SSA appeal form (available by request from SSA) or by sending SSA a signed letter stating that the individual wishes to appeal the decision and including his or her Social Security number. If the individual does not appeal within 60 days, he or she may lose the right to do so. In that case, the last SSA decision is final. If the person has good reason for not appealing within the time limit, he or she may request more time. The individual must request more time from the SSA in writing, and must state the reason for the delay.

Requesting Continued Benefits during the Appeal Process

An individual may request that SSA continue to pay his or her benefits while SSA is making a decision on an appeal if the individual is appealing a decision that he or she can no longer get Social Security disability benefits because his or her medical condition is not disabling. In order for benefits to continue, the request must be made within ten days of the date of receipt of the letter from SSA informing the individual of the decision. If the individual's appeal is denied, he or she may have to pay back any money that he or she was not eligible to receive.

Repayment Process if an Appeal to the Administrative Law Judge is Denied

If an appeal is denied, the individual and his or her Representative Payee (if applicable) will receive a notice of the Administrative Law Judge decision. If repayment of SSA benefits is required, individuals may repay in a lump sum or arrange with SSA to repay in installments (at least $10 per week) over a 12-month period. If repayment within 12 months is not possible, repayment may be spread over 36 months. Alternatively, if the individual is receiving other benefits from SSA, he or she may choose to have their benefits reduced by the amount of the repayment obligation until the funds are repaid.

Representative Payee Program

A representative payee (RP) is a person, agency, organization, or institution selected by SSA to manage an individual's payments when the individual is physically or mentally unable to do so. Before appointing a representative payee, SSA evaluates medical evidence and other information about the beneficiary's ability to manage his or her SSA benefit payments.

SSA requires that a representative payee be named for an individual who is under the age of 18 or is a legally incompetent adult, or anyone whom SSA determines to be incapable of managing or directing the management of his or her funds.

SSA may appoint any of the following as representative payee for an individual in accordance with the following preferences:

- A person, other than a convicted felon, who is concerned with the individual's welfare (usually a spouse, close relative, guardian, or friend)

- The director of a residential institution, such as a nursing home or health care provider, including the director of a voluntary agency
- A public or nonprofit agency or financial organization

The agency operating the new residential program is required under OPWDD regulations to file to become representative payee within three business days after the individual's placement.

Duties of a Representative Payee

The representative payee is responsible for:

- Using Social Security payments for the individual's current basic needs for food and shelter

- Reporting changes in the individual's circumstances to SSA (see the Reporting Responsibilities part of this section)

- Providing a simple accounting to SSA and to the individual about how the money was spent (SSA usually requests an accounting each year)

- Responding on the individual's behalf to any SSA requests for action or information

The representative payee's authority is limited to matters between the individual and SSA. The representative payee may, at any time, request that SSA change or terminate the payee arrangement (following such a request, SSA will investigate the situation and make a decision regarding a successor payee).

When an individual moves from one residential program to a residential program operated by a new agency, the individual's representative payee will probably change. During the transition from one payee to another, an individual's conserved Social Security monies must be returned to the Social Security Administration in order to be reissued to the new payee. Voluntary agencies must follow OPWDD regulations regarding the handling of personal allowance.

As representative payee, the agency is responsible for keeping records and reporting on how it spends the benefits by completing a Representative Payee Report (Form SSA-623, SSA-6230 or SSA-6233). The appropriate form is mailed to the representative payee about once a year. SSA may randomly do a brief onsite review of representative payee agency. The objective of such reviews is to ensure that agency's performance as payee conforms to SSA policies.

Further information regarding the duties of a representative payee can be found at the Social Security website: www.ssa.gov or www.socialsecurity.gov.

Work Incentives

What Are Work Incentives?

Many people with disabilities want to work, but are concerned about how earnings will affect the benefits they receive under Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). The Social Security Administration (SSA) provides incentives to help people who are blind and disabled achieve greater independence through employment without jeopardizing their SSI or Medicaid benefits.

Work incentives allow an individual to test his or her ability to work and possibly become self-supporting and independent. These supports are intended to help people with disabilities enter or re-enter the workforce by protecting their eligibility for benefits and/or health coverage.

Substantial Gainful Activity

An individual's initial and continued eligibility for Social Security disability benefits is contingent upon whether he or she is able to engage in substantial gainful activity (SGA). SGA is the performance of significant and productive physical or mental work for pay or profit. Evaluation of SGA also applies to a disabled individual's initial eligibility for SSI, but does not apply to SSI applicants who are blind.

A dollar amount is designated for the SGA level. For 2014, the SGA level for non-blind individuals is $1,070. For blind individuals, the SGA level is $1,800.

More information about SGA can be found in the SSI section of this guide and on the SSA website at: www.ssa.gov.

Trial Work Period

An individual receiving Social Security disability (SSDI) benefits is allowed a trial work period (TWP) consisting of at least 9 months, not necessarily consecutive, within a 60-month period. A month is counted as a trial work period month if the person's earnings for that month are greater than or equal to the current TWP amount set by SSA. For 2014, the TWP amount is $770. During the individual's TWP, if the individual continues to be disabled, he or she continues to receive the full amount of his or her SSDI benefits, regardless of the amount of his or her earnings. After the individual's 9-month trial work period is completed, SSA does a review to decide whether the individual is able to work in spite of a disabling impairment. SSA then makes a determination of whether benefits will continue or end.

After the TWP, a recipient will receive a 36-month extended period of eligibility during which SSDI benefits can be paid for each month the individual does not perform

substantial gainful activity. The extended period of eligibility applies only if the individual continues to meet the SSA definition of disability.

If a disabled person has Medicare Part A and Part B coverage, his or her coverage will continue for at least 93 consecutive months starting the month after the last month of the TWP.

Subsidies and Special Conditions

Subsidies and special conditions are terms for support an individual receives on the job that may result in the individual receiving more pay than the actual value of the services he or she performs.

Subsidy is support provided by the individual's employer. Special conditions are generally provided by someone other than the employer, such as a vocational rehabilitation agency. A job coach can be an example of either a subsidy or a special condition depending on whether the coach is provided by the employer or someone else.

SSA deducts the value of subsidies and special conditions from the individual's earned income when deciding whether the individual is working at the SGA level.

For an SSI recipient, the amount of the individual's total gross monthly earnings is not adjusted by the amount of subsidies or special conditions included in it when the earnings amount is used to calculate the SSI payment.

Ticket to Work

Under the Ticket to Work program, individuals receiving SSI and/or SSDI receive a "Ticket", which they can use for obtaining employment services, vocational rehabilitation services, and other support services they may need to get or keep a job. Use of the Ticket is voluntary and there is no penalty to individuals who choose not to use it.

Services provided to individuals under this program must be rendered by an approved Employment Network (EN) or State Vocational Rehabilitation (VR) agency. Services are provided at no cost to the individual.

SSA does not conduct CDRs when an individual is using a Ticket to Work.

Earned Income Exclusion

The earned income exclusion allows most of a person's earned income, including pay received in a sheltered workshop or work activities center, to be excluded when figuring the SSI payment amount. SSA excludes the first $65.00 of monthly gross earnings plus one-half of the remainder. This means that less than half of a person's earnings are counted when calculating the SSI payment amount (i.e., the SSI benefit is reduced by $1.00 for every $2.00 in earnings over $65.00)

The earned income exclusion is applied to the individual's monthly income in addition to the $20.00 general income disregard. This $20.00 disregard is always applied first to any unearned income, but is applied to earned income if the person has no unearned income. If a person has unearned income of less than $20.00, the remainder of the $20.00 disregard is applied to the person's earned income, before the $65.00 and one-half exclusions.

Student Earned Income Exclusion

The student earned income exclusion allows an SSI recipient who is under age 22 and regularly attending school to exclude earned income each month (subject to the monthly limit) up to the annual limit. For 2014, the monthly limit for the SSI Student Earned Income Exclusion is $1,750 and the annual limit is $7,060. When the SSI payment is calculated, the student earned income exclusion is applied before the general income disregard or the earned income exclusion.

Impairment-Related Work Expenses (IRWE)

The costs of certain impairment-related items and services that a person needs to work are deducted from earnings in figuring substantial gainful activity, even if these items and services are also needed for non-work activities. For expenses to qualify as IRWEs, the individual must apply to SSA and provide appropriate documentation of the expenses.

An impairment-related item or service is considered an IRWE under the following conditions:

- The item or service enables the person to work
- The item or services is needed because of a disabling impairment
- The person paid the cost of the item or service and was not reimbursed by another source (e.g., Medicare, Medicaid, or private insurance)
- The cost is "reasonable" – that is, it represents the standard charge for the item or service in the community
- The expense was paid in a month that the person had earned income or performed work while using the impairment-related item or service

If a person has IRWEs, SSI excludes those expenses in determining the amount of countable earned income used to calculate the person's SSI payment. The exclusion of IRWEs is calculated after the $65.00 earned income exclusion, but before the additional earned income exclusion of one-half of the remaining earned income.

The following are some examples of Impairment Related Work Expenses:

- Modifications made to an automobile to allow the disabled person to drive
- Wheel chair ramps
- Special foods to maintain dietary restrictions at work
- One-handed typewriter

- Interpreter for the deaf
- Typing aids

Example – Impairment-Related Work Expenses

The following example shows the effect of Impairment Related Work Expenses on an individual's SSI payment amount.

Karl is disabled and lives alone. He receives SSI and has monthly gross earned income of $361.00. He has no unearned income. SSA has approved Impairment Related Work Expenses of $100.00 per month for Karl.

	Without IRWE	**With IRWE**
Gross Monthly Earned Income	$361.00	$361.00
Less General Income Disregard	- 20.00	- 20.00
	$341.00	$341.00
Less Earned Income Exclusions		
$65.00	- 65.00	- 65.00
	$276.00	$276.00
Impairment-Related Work Expenses		**- 100.00**
		$176.00
One-half the remainder	÷ 2	÷ 2
Countable Earned Income	**$138.00**	**$ 88.00**
SSI Payment Level (2014)		
– Living Alone	$808.00	$808.00
Less Countable Income	- 138.00	- 88.00
SSI Payment	**$670.00**	**$720.00**

Blind Work Expenses (BWE)

Blind work expenses are costs a blind person pays from his or her own funds when he or she works. The expenses do not need to be related to the person's blindness. For expenses to qualify as BWEs, an individual must apply to SSA and provide them with appropriate documentation of the expenses. The approved expenses are then deductible from the individual's earnings as BWEs.

The amount of earned income a blind person uses to meet these expenses does not count in determining SSI eligibility and in calculating the amount of the person's SSI payment amount if the person is:

- Under age 65
- Age 65 or older and received SSI payment based on blindness for the month before he or she attained age 65
- Age 65 or older and received payments under a former state plan for aid to the blind for the month before he or she attained age 65

BWEs can be applied only if the person is receiving SSI payments because of blindness and if the person is paying the BWEs.

In calculating the person's SSI payment, the BWE exclusion is applied to the person's gross monthly earned income immediately after applying any portion of the general income disregard ($20.00) that could not be deducted from unearned income and all other earned income exclusions except the income set aside to fulfill an approved Plan to Achieve Self Support (PASS).

The following are some examples of BWEs:

- Service animal expenses
- Transportation to and from work
- Federal, state, and local income taxes
- Social Security taxes
- Attendant care services
- Visual and sensory aids
- Translation of materials into Braille
- Professional association fees
- Union dues

The following example shows the effect of Blind Work Expenses on an individual's SSI payment amount.

Derrick is blind. SSA has approved Blind Work Expenses of $40.00 per month for Derrick for the care and maintenance of his guide dog. Derrick receives SSI and has gross monthly earnings of $361.00 and no unearned income. He lives in his own apartment.

Example – Blind Work Expenses

	Without BWE	With BWE
Gross Monthly Earned Income	$361.00	$361.00
Less General Income Disregard	- 20.00	- 20.00
	$341.00	$341.00
Less Earned Income Exclusions $65.00	- 65.00	- 65.00
	$276.00	$276.00
One-half the remainder	÷ 2	÷ 2
	$138.00	$138.00
Blind Work Expenses (BWE)		**- 40.00**
Countable Earned Income	**$138.00**	**$ 98.00**
SSI Payment Level (2014) – Living Alone	$808.00	$808.00
Less Countable Income	- 138.00	- 98.00
SSI Payment	**$659.00**	**$710.00**

Plan for Achieving Self-Support

A Plan for Achieving Self-Support (PASS) allows an SSI recipient with a disability to set aside income and/or resources for a specified period of time for an SSA-approved work goal. The individual may also exclude part of his or her ineligible spouse's income and resources. If the person is a child age 15 or older and living with his or her parents, he or she may also exclude part of the parents' income and resources.

The money set aside under an approved PASS is not counted for initial or continuing SSI eligibility decisions (i.e., income and resources that are set aside are excluded under the SSI income and resources tests). Having a PASS may help an individual qualify for SSI or may increase the amount of the individual's SSI payment.

Unlike IRWEs, the person may use a PASS to exclude unearned income and resources as well as earned income. SSI does not count income or resources set aside under a PASS when calculating the SSI payment amount. Usually, the person cannot use his or her SSI payment for the expenses necessary to reach is or her occupational goal because the SSI is needed to pay for ordinary living expenses.

To request approval of a PASS, the individual must submit the details of the plan to SSA in writing. SSA staff is available to assist with writing a PASS. A list of SSA contact information can be found at www.ssa.gov.

Examples of Plans for Achieving Self-Support are setting aside money to go back to school or to obtain specialized training for a job. The goal of a PASS should be to allow

the person to earn enough to reduce or eliminate his or her need for benefits provided under the Social Security or Supplemental Security Income programs.

Property Essential to Self-Support

Property Essential to Self-Support (PESS) allows an SSI recipient to exclude certain resources that are essential to the person's means of self-support. Property used in a trade or business or used by a person for work as an employee is totally excluded. For example, the value of tools or equipment that a person needs for work is totally excluded.

Special SSI Payments for People who Work – Section 1619(a)

Under section 1619(a) of the Social Security Act, SSI beneficiaries are allowed to receive SSI cash payments even when their earned income (gross wages and net earnings from self-employment) exceeds the substantial gainful activity level. The earned income is not excluded but is used in the calculation of the person's SSI payment. To qualify for this incentive, the person must:

- Be eligible for an SSI payment for at least one month before he or she begins working at the substantial gainful activity level
- Have the same disability as when he or she applied for SSI
- Meet all other eligibility rules, including the income and resource tests

Under 1619(a), the person remains eligible for Medicaid because he or she continues to be in receipt of SSI.

Example – Section 1619(a)

Ed is disabled and has been an SSI cash payment recipient for 10 years. He does not have any other benefit and he is not blind. Recently he took a job that pays him $1,100 per month. He continues to be disabled and his resources are less than $2,000 (the SSI resource limit). Ed can continue to receive SSI cash payments because of the 1619(a) provisions even though his earnings exceed the 2014 Substantial Gainful Activity level of $1,070 per month.

Continued Medicaid Eligibility – Section 1619(b)

Under section 1619(b) of the Social Security Act, Medicaid coverage continues for most working SSI beneficiaries when their earnings become too high to allow for an SSI cash payment. To qualify for this incentive, a person must:

- Have been eligible for an SSI cash payment for at least one month
- Still meet the disability requirement for SSI
- Still meet all other requirements for SSI
- Need Medicaid in order to work
- Have gross earned income that is insufficient to replace SSI, Medicaid, and any publicly-funded attendant care

Example – Section 1619(b)

Susan has been receiving an SSI cash payment for 5 years. She lives in a VOIRA. She recently began working at a local department store and her total income is $700.00 from wages and $800.00 from Social Security (both earned and unearned) per month. Her SSI has been terminated. She continues to be disabled and she would not be able to work if she did not have her Medicaid coverage. She meets all other SSI eligibility requirements. Susan can continue to receive her Medicaid coverage even though her SSI payments have been discontinued.

Continued Payment under a Vocational Rehabilitation Program or Similar Program – Section 301

An individual participating in an appropriate program of vocational rehabilitation (VR), or similar service, who is determined to be no longer disabled due to medical improvement, may continue receiving SSI and SSDI benefits until their participation in the vocational rehabilitation program ends. In order to qualify for continued payments under Section 301, the individual must have started the VR service before their disability ended under SSA rules. In addition, SSA has to review the VR program and determine whether continued participation in the program will increase the likelihood of permanent removal from the disability benefit rolls.

Appropriate programs are The Ticket to Work, VR programs using an individualized plan for employment, support services that use an individualized written employment plan, PASS, or an individualized education program (IEP) for an individual age 18 through 21.

Expedited Reinstatement of Benefits

An individual whose Social Security disability benefits were terminated because of work activity can request reinstatement of his/her benefits. The person must be unable to work because of the same or related original medical condition and must file the request for reinstatement within 60 months from the month of termination. The individual may be able to receive provisional SSI payments while SSA decides whether the person meets the reinstatement requirements.

Additional Information about Work Incentives

Additional information about work incentives is available in the SSA Red Book or from the SSA at their toll-free number: 1-800-772-1213 or on their website at: www.ssa.gov.

Medicare

What is Medicare?

Medicare is health insurance for people age 65 or older, under 65 with certain disabilities, and any age with end-stage renal disease. Medicare was established to provide hospital and medical insurance protection to people who might not otherwise be able to afford health insurance. In this way, Medicare is designed to protect aged and disabled persons against the expenses of illnesses that could otherwise exhaust their savings. Eligibility for Medicare begins after a 24-month waiting period when a disabled individual becomes eligible to collect Social Security benefits. Medicare is administered by the Centers for Medicaid and Medicare Services (CMS).

The Centers for Medicaid and Medicare Services (CMS) publishes a pamphlet, **Your Medicare Benefits**, which provides coverage and payment charts that show services covered under Medicare Part A and Part B. A copy of this pamphlet is available by calling 1-800-MEDICARE (1-800-633-4227) and at www.medicare.gov.

Who is Eligible for Medicare?

A person is eligible for Medicare if he or she has worked for at least 10 years in Medicare-covered employment, is at least 65 years old, and is a citizen or permanent resident of the United States. Citizens and permanent residents of the United States who are younger than 65 years of age may qualify for coverage if they have certain disabilities or have end-stage renal disease (permanent kidney failure requiring dialysis or transplant).

Although the eligibility age for full Social Security Retirement benefits varies based on a person's date of birth, the age of Medicare eligibility for people who are not disabled and do not have end-stage renal disease remains at 65.

Four Components of Medicare

An individual may be eligible for different Medicare components depending on their situations and preferences. Medicare has the following four components.

1. Medicare Part A – Hospital insurance
2. Medicare Part B – Medical insurance
3. Medicare Part C – Medicare Advantage Plans
4. Medicare Part D – Prescription drug coverage

Each part of Medicare is discussed on the pages that follow.

Section 10: Medicare

Medicare Part A – Hospital Insurance

Medicare Part A, the hospital insurance component of Medicare, helps pay for care in hospitals and skilled nursing facilities, hospice services, and some home health care.

Most people do not pay a monthly premium for Part A because the coverage is based on a work record where Medicare taxes have already been paid.

A person who did not pay Medicare taxes while working but is age 65 or older may be able to buy Part A coverage. New York State will pay the Medicare Part A premium for New York State residents who receive Supplemental Security Income and are not entitled to premium-free Part A due to insufficient work history.

Medicare Part A Eligibility

A citizen or permanent resident of the United States is eligible for Medicare Part A if he or she is:

- Age 65 or older
- Under age 65 and meets one or more of the following requirements:
    - Entitled to Social Security disability benefits for 24 months based on a disability determination made at age 18 or later
    - Entitled to Railroad Retirement disability benefits for 24 months
    - Entitled to Social Security or Railroad Retirement disability benefits and has amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
        - **Note:** There is no 24-month waiting period for an individual with ALS.
    - Would be entitled to Social Security disability benefits for more than 24 months if his or her federal employment were covered under the Social Security Act.
    - Is the child or widow(er) age 50 or older, including a divorced widow(er) of someone who has worked long enough in a government job where Medicare taxes were paid and meets the requirements of the Social Security disability program
    - Lost entitlement to disability benefits and hospital insurance solely because of substantial gainful activity (SGA) (a premium would be required, but it may be paid by Medicaid)

- Any age with end stage renal disease (permanent kidney failure) treated by a kidney transplant or regular dialysis and:

    - Is eligible for or receive monthly benefits under Social Security or the railroad retirement system; or
    - Has worked long enough in a Medicare-covered government job; or
    - Is the child or spouse (including a divorced spouse) of a worker (living or deceased) who has worked long enough under Social Security or in a Medicare-covered government job.

Medicare Part A Enrollment Process

An individual who receives Social Security retirement or Railroad Retirement (RRB) benefits is automatically enrolled in Medicare Part A on the first day of the month of his or her 65th birthday. An individual receiving Social Security disability or RRB disability benefits is automatically enrolled in Medicare Part A after receiving disability benefits for 24 months; benefits start on the 25th month. About three months before the person becomes eligible for Medicare, he or she will receive information about Medicare.

If an individual is not receiving Social Security or RRB benefits before his or her 65th birthday, he or she has to apply for Medicare Part A in order to obtain coverage.

Certain aged people who do not qualify for Medicare Part A (hospital insurance) under the requirements stated above may be eligible by paying a monthly premium (see 2014 Medicare Costs, page 316, for premium and deductible amounts for Part A). If a person chooses to purchase Part A coverage, he or she must also enroll in Part B (medical insurance).

To enroll in Medicare Part A, the individual or representative should call the Social Security Administration at 1-800-772-1213. If the individual was a railroad employee or receives benefits from the Railroad Retirement Board, he or she should call either the local RRB office or 1-800-808-0772 to get information for enrolling in Part A.

The New York State Department of Health will pay the Medicare Part A premium for individuals who are 65 years old or older, receive Supplemental Security Income benefits, and have not earned enough work credits to qualify for free Medicare Part A.

Medicare Part B – Medical Insurance

Medicare Part B, the medical insurance component of Medicare, helps pay for physician's services, outpatient hospital care, and some other medical services that Medicare Part A does not cover, such as the services of physical and occupational therapists and some home health services. Part B helps pay for covered doctor services and supplies that are medically necessary.

Medicare Part B Eligibility

A person is eligible for Medicare Part B if he or she is entitled to premium-free Medicare Part A or is age 65 or older, a resident of the U.S., and a citizen of the U.S. Non-citizens lawfully admitted for permanent residence, who have resided in the U.S. for five continuous years immediately prior to the month of enrollment, are also eligible.

There is a monthly premium for Medicare Part B. The amount of the premium usually changes each January at the time of the Social Security Cost of Living Adjustment. In some cases, an individual's premium amount may be higher if the individual did not choose Part B when he or she first became eligible. The cost of Part B may go up 10% for each 12-month period that the individual could have had Part B but did not enroll.

Medicare Part B Enrollment Process

1. A person who receives Social Security retirement or Railroad Retirement benefits is automatically enrolled in Medicare Part B on the first day of the month of his or her 65th birthday.

2. A disabled person under 65 who has received Social Security disability or Railroad Retirement disability benefits for 24 months will be automatically enrolled as of the 25th month of disability entitlement. About three months before the person becomes eligible for Medicare, he or she will receive information about how to turn down Medicare Part B coverage, if he or she wishes to do so.

3. A person who has not been automatically enrolled because he or she is receiving Social Security retirement or Railroad Retirement benefits has the opportunity to enroll in Part B coverage during a seven-month enrollment period beginning on the first day of the third month before the month the person first becomes eligible to enroll. The enrollment period ends on the last day of the third month following the month the person was first eligible to enroll.

4. A person who failed to enroll during his or her initial enrollment period may enroll only during the open enrollment period that runs from January 1 through March 31 of each year. For open enrollments, Medicare Part B coverage will begin on July 1 of the year of enrollment. The premium for a person who enrolls after his or her initial enrollment period or re-enrolls after having had coverage terminated is usually increased by 10% for each full 12-month period that the person could have had Medicare Part B, but did not take it.

5. There is a special enrollment period for an individual who did not enroll for Medicare when he or she was first eligible because the individual or his or her spouse was still working and had coverage through an employer or union. In this situation, the individual can enroll for Medicare with no premium penalty:

    - At any time, if he or she is covered under a group health plan based on his or her own or a spouse's current employment
    - During the eight-month period following the month that the employer (or union) group health plan coverage ends, or when the employment ends (whichever occurs first)

6. The special enrollment period rules also apply to an individual who is disabled and working, or who has coverage from a working family member.

7. The Medicare Part B premium is usually deducted from the individual's monthly Social Security, Railroad Retirement, or Civil Service Retirement payment. If the individual does not receive any such payments, Medicare sends the individual a bill for the Part B premium every three months (see 2014 Medicare Costs, page 316, for premium and deductible amounts for Part B).

8. New York State pays the monthly premium for some Part B eligible people. These individuals include SSI recipients who are enrolled in Medicare, Qualified Medicare beneficiaries, and certain SSA beneficiaries who receive Social Security disability benefits including Disabled Adult Child benefits.

Medicare Part C – Medicare Advantage Plans

Medicare Advantage plans provide people with more choices and sometimes, extra benefits. There are three types of Medicare Advantage plans:

- Medicare Managed Care Plans
- Medicare Preferred Provider Organization Plans
- Medicare Private Fee-for-Service Plans

These plans provide care under contract to Medicare. All Medicare Advantage Plans must cover at least the same services covered by Medicare Part A and Part B. In addition, the plans must offer prescription drugs through the Medicare Part D Medicare Advantage prescription plans. Some plans may also offer additional coverage beyond the prescribed minimum set by the Medicare program.

The Medicare beneficiary's costs for Part C coverage may be different from his or her costs for Medicare Parts A and B and the individual may have to pay a monthly premium for extra benefits.

The Centers for Medicare and Medicaid Services' (CMS) website, www.medicare.gov, provides information about Medicare Advantage Plans. A search for these plans can be done using the individual's zip code. Information about selecting a plan can also be found on this website.

Medicare Part C Eligibility

A person who wishes to choose a Medicare Part C - Medicare Advantage Plan must meet the following criteria:

- Be enrolled in both Medicare Part A and Medicare Part B
- Continue to pay the monthly Medicare Part B premium
- Live in the service area of the plan
- Not have end-stage renal disease

Medicare Part C Enrollment

Enrollment for Medicare Part C is an enrollment for a Medicare Advantage Plan subject to the eligibility requirements listed above. Enrollment in this program can be done at the time of initial enrollment in both Part A and Part B or at any time during the year if the managed care plan allows. Otherwise, a person can enroll during the open enrollment period between November 15 and December 31 of each year as long as the managed care plan is accepting new members.

Medicare Part D – Medicare Prescription Drug Coverage

Medicare Part D is available to Medicare beneficiaries. This coverage helps Medicare eligible people pay prescription drug costs. Although it is primarily designed to provide the elderly with affordable prescription drug coverage through the Medicare program, all people who have Medicare coverage, regardless of age, are eligible for the benefit.

The federal government, through the Centers for Medicare and Medicaid Services (CMS), has set minimum program standards for Part D coverage and called upon private insurance companies to establish drug coverage plans that meet or exceed the program's basic coverage standards. See 2014 Medicare Part D Cost Sharing, page 318, for the basic coverage plan established for Medicare Part D.

Medicare Part D Eligibility

Participation in Medicare Part D is voluntary for most Medicare beneficiaries, but is mandatory for people who receive both Medicare and Medicaid benefits. People who receive both Medicare and Medicaid benefits are referred to as "dual eligibles". The majority of the individuals served by OPWDD are dual eligibles and are therefore required to participate in Medicare Part D.

Medicare Part D Creditable Coverage

Dual eligibles that have health insurance coverage through an employer or union may have prescription coverage equal to or better than Part D. The employer or union must provide a statement that the individual has creditable coverage and will lose the health insurance if enrolled in Medicare Part D. A copy of the letter must be provided to the Medicaid local district.

Medicare Part D Benchmark Plans

When Medicare Part D became available, dual eligibles were automatically enrolled in a "benchmark" prescription drug plan and their Medicaid stopped covering their prescription drugs. Benchmark plans are plans that meet all of the minimum Medicare Part D standards for coverage and cost. Medicare, through the individual drug plans, notified dual eligibles of the plan in which he or she was automatically enrolled. New dual eligibles are now automatically enrolled in benchmark plans on an ongoing basis and have the option to switch plans if it is not meeting their needs. See Transition to 2014 Medicare Part D Prescription Drug Plans, page 317, for a list of qualifying plans.

Medicare Part D Drug Coverage and Enrollment

If a dual eligible person's Medicare prescription drug plan does not cover one or more of his or her drugs, the Medicaid program will not cover the drug(s) either. Medicaid will cover benzodiazepines, barbiturates, and certain over-the-counter drugs that are excluded from Medicare Part D coverage. All other categories of drugs included in the Medicare Part D benefit will be covered only through the Medicare Part D program for dual eligibles.

If a dual eligible person finds that a plan does not meet his or her needs, he or she can change plans once a month at any time during the month. The new plan will take effect

on the first of the month following the month in which the change is made. To avoid monthly premiums, the person must choose a plan from the benchmark plans available. The individual can change plans by contacting Medicare and asking to be enrolled in the new plan or by contacting the new plan and following instructions for enrollment. Enrolling in a new plan will automatically remove the individual from his or her old plan as of the first of the month following the month in which the change is made.

How to Determine and Identify Part D Enrollment

To find out about a person's enrollment, the following information is required:

- The person's Medicare claim number
- The person's last name
- The person's date of birth
- The effective date of the person's Medicare Part A or Part B coverage
- The person's zip code or the person's representative payee's zip code

Current enrollment information can be accessed at the Medicare website at: www.medicare.gov/mpdpf and using the following process:

1. On the Medicare website, scroll down to the area labeled "Where would you like to begin?" and click on "Find a Medicare Prescription Drug Plan".

2. Enter the demographic information in the spaces provided under "A. Personalized plan search". This screen is case sensitive, so enter the person's surname using the standard capitalization rules.

3. Click the button labeled "Search Plans". If the person is enrolled in a prescription drug plan, the information will appear immediately. If the person is not enrolled, the general search screen will appear.

4. Go no further to avoid enrolling the person into a new plan. Only designated voluntary and DDSOO staff may take this type of action. Information on OPWDD regulations about Part D enrollment and representation can be found in 14 NYCRR Subpart 635-11 (Enrollment in a Medicare prescription drug plan). This information can be accessed using the OPWDD website at www.opwdd.ny.gov.

Please call 1-800-MEDICARE (1-800-633-4227) for assistance with problems using this procedure.

Medicare Part D - What to do if the Pharmacy will not Fill a Prescription

Medicare Part D has a "transition" policy for people moving from their previous prescription drug programs into a Medicare Part D plan. The policy allows a newly enrolled person to receive a one-time only filling of a prescription not covered by his or her Medicare Part D prescription drug plan. After obtaining the filled prescription, the person is expected to try to get his or her plan to cover the drug or to get his or her physician to prescribe a different drug that is covered by the plan.

An individual or his or her authorized representative has the right to get a written explanation from his or her Medicare Prescription Drug Plan if a request for a prescription drug is denied. Some reasons an individual might ask for a written explanation are if the pharmacist tells the individual that his or her prescription drug plan will not cover a prescription or the individual is asked to pay more than he or she thinks he or she is required to pay. The individual also has the right to ask the prescription drug plan for an exception if the individual and his or her doctor believe he or she needs a prescription drug that is not on his or her prescription drug plan's list of covered prescription drugs.

If the individual disagrees with the information provided by a pharmacist, the individual or authorized representative can contact his or her plan to ask for a coverage determination. The pharmacy will give or show the individual a notice that explains how to contact his or her Medicare drug plan.

A standard request must be made in writing unless the individual's plan accepts requests by phone. The individual or his or her doctor can call or write his or her plan for an expedited (fast) request. Once the individual's Medicare drug plan gets his or her request for a coverage determination, the Medicare drug plan has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify the individual of its decision. If the individual is requesting an exception, his or her prescribing doctor must provide a statement explaining the medical reason why the individual's request should be approved. The individual's plan generally has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify the individual of its decision once the plan receives the individual's doctor's statement.

If the individual disagrees with the Medicare drug plan's decision, he or she has the right to appeal. The individual must request the appeal within 60 calendar days from the date of the decision. A standard request must be made in writing unless the individual's Medicare drug plan accepts requests by phone. The individual can call or write the plan for an expedited request. Once the Medicare drug plan receives the individual's request for an appeal, the Medicare drug plan has seven days (for a standard request for coverage) or 72 hours (for an expedited request for coverage) to notify him or her of its decision.

If the plan does not respond to the individual's request for a drug, an appeal, or an exception, the individual can file a grievance with the plan sponsor, or file a complaint by calling 1-800-MEDICARE (1-800-633-4227), or both.

If the plan continues to deny the prescription drug, the person can continue through the appeal process as described below.

Medicare Part D Subsidy - Low Income Subsidy/Extra Help

Part D enrollees who have limited income and resources may be eligible for a Part D subsidy that provides reduced monthly premiums and other cost-sharing assistance. Dual eligibles, by definition, are low income as indicated by their receipt of Medicaid

benefits. Medicare Part D premiums and deductibles are subsidized for low-income people in benchmark plans, but individuals remain responsible for co-payments for each filled prescription. Unlike the Medicaid program, Medicare co-payments must be paid in order to obtain the drugs. Pharmacies cannot waive Medicare co-payments unless it is in an individual, unadvertised manner. It is OPWDD policy that individuals in state operated or voluntary provider agencies have their co-payments paid by their respective DDSOOs or voluntary agencies. See 2014 Medicare Part D Cost Sharing, page 318, for low-income cost sharing eligibility and amounts.

There are several options for applying for the low-income subsidy (also referred to as "Extra Help"). Applications may be completed online at www.ssa.gov or www.socialsecurity.gov or by use of a scannable paper form, which can be obtained from any Social Security office or by calling SSA's toll-free number 1-800-772-1213. It is important that applicants do not complete a photocopied, faxed or downloaded copy of the application. Using any paper form of the application other than the form provided directly from SSA could cause a delay in processing the application. Applicants may also elect to visit the local SSA office in person to complete the application.

Lifetime Reserve Days

Lifetime Reserve Days apply to individuals enrolled in Medicare Part A and/or Part B and are additional days that Medicare will pay for when a beneficiary is in a hospital for more than 90 days. Each beneficiary has 60 reserve days that can be used during his or her lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily co-insurance amount.

A beneficiary (or someone acting on his or her behalf) may make an election not to use lifetime reserve days at the time of admission to a hospital or at any time thereafter, subject to the limitations on retroactive elections described below. Hospitals are required to notify patients who have already used or will use 90 days of benefits in a benefit period that they can elect not to use their reserve days for all or part of a stay. The hospital should make available an appropriate election statement or form to be included in the patient's hospital record if the patient elects not to use reserve days.

If a patient elects not to use reserve days, covered Part B services are billed to the intermediary. A Medicare beneficiary who is eligible for medical assistance (Medicaid) under a state plan should be advised that such assistance would not be available if the beneficiary elects not to use the lifetime reserve days.

In the following situations, a beneficiary will be deemed to have elected not to use lifetime reserve days:

- The average daily charge for covered services furnished during a lifetime reserve billing period is equal to or less than the coinsurance amount for lifetime reserve days and
    - The hospital is reimbursed on a cost reimbursement basis, or
    - The hospital is reimbursed under the prospective payment system and lifetime reserve days are needed to pay for all or part of the outlier days
- For the non-outlier portion of a stay in a hospital reimbursed under the prospective payment system (acute hospital PPS, inpatient rehabilitation facility (IRF) PPS and a normal stay under long-term care hospital (LTCH) PPS), if the beneficiary has one or more regular (non-lifetime reserve) days remaining in the benefit period upon admission to the hospital. The exception to this rule is the short stay outlier policy under LTCH PPS.
- The beneficiary has no regular days available at the time of admission to a hospital reimbursed under the prospective payment system and the total charges for which the beneficiary would be liable if lifetime reserve days are not used is equal to or less than the charges for which the beneficiary would be liable if he or she used lifetime reserve days (i.e., the sum of the coinsurance amounts for the lifetime reserve days that would be used plus the total charges for outlier days), if any, for which no lifetime reserve days would be available because lifetime reserve days are exhausted.

Exception: Even though a beneficiary would otherwise be deemed to have elected not to use lifetime reserve days, he or she will not be so deemed where benefits are available from another third-party payer to pay some or all of the charges, and the third party requires, as a condition of payment, that lifetime reserve days be used. In such cases, lifetime reserve days will be used unless the beneficiary specifically elects not to use them.

Ordinarily, an election not to use reserve days will apply prospectively. If the election is filed at the time of admission to a hospital, it may be made effective beginning with the first day of hospitalization or with any day thereafter. If the election is filed later, it may be made effective beginning with any day after the day it is filed.

A beneficiary may retroactively elect not to use reserve days provided when:

- The beneficiary (or some other source) offers to pay the hospital for any of the services not payable under Part B, and
- The hospital agrees to accept the retroactive election

In this case, the hospital will contact the intermediary for procedures for correcting any claims already submitted. A retroactive election not to use the lifetime reserve days must be filed within 90 days following the beneficiary's discharge from the hospital unless benefits are available from a third-party payer to pay for the services and the hospital agrees to the retroactive election. In that case, the beneficiary may file an election not to use the lifetime reserve days later than 90 days following discharge.

Medicare Savings Program

The New York State Department of Health will pay for the Medicare Part A and Medicare Part B premiums for certain individuals through the Medicare Savings Program.

The Medicare Part A premium will be paid by NYS DOH for individuals who are 65 years old or older, receive Supplemental Security Income benefits less than 100% of the Federal Poverty Level, and are not eligible for free Medicare Part A.

The chart on the following page indicates the groups of individuals for whom NYS DOH will pay the Medicare Part B premium. The application form for the Medicare Savings Program can be found in the Additional Resources section (Medicare Savings Program Application (DOH-4328), page 319).

Medicare Savings Program Chart

Group	Part B Buy-In Eligibility Requirements	Income Requirements	Resources Requirements	Age Requirements
SSI Beneficiaries	In receipt of SSI and eligible for Medicare	SSI cash recipient	$2,000 or less; may also have a burial fund	65 or over or under 65 and receiving Social Security Disability/ Railroad Retirement benefits for 24 months
Pickle Amendment (Section 503 of Public Law 94-566) - Lost SSI cash benefit as a result of a Social Security Cost of Living Adjustment (COLA) increase	Automatically eligible if eligible for Medicare	After disregarding annual Social Security COLA increases from income, must continue to meet all other eligibility requirements for SSI	$2,000 or less; may also have a burial fund	20 or older
Disabled Adult Child (DAC) - Lost SSI cash benefit due to either an initial DAC benefit or an increase in the DAC benefit other than a COLA increase	Automatically eligible if eligible for Medicare – a DAC individual may be a QMB (see below)	After disregarding the DAC benefit or increase in the DAC benefit from income, must continue to meet all other eligibility requirements for SSI	$2,000 or less; may also have a burial fund	20 or older
1619 (b) Individuals (Social Security Act Section 1619(b))	Automatically eligible if eligible for Medicare	Must have gross earned income that is insufficient to replace SSI, Medicaid, and any publicly funded attendant care	$2,000 or less; may also have a burial fund	20 or older
Qualified Medicare Beneficiary (QMB)	Age 65 or older, receiving SSI, and eligible for free Medicare Part A or Part A Buy-In	Up to or equal to 100% of Federal Poverty Level*	No Resource Test	20 or older or 65 or older for SSI beneficiaries
Specified Low Income Medicare Beneficiary (SLIMB)	Eligible for free Medicare Part A	Up to 120% of the Federal Poverty Level*	No Resource Test	20 years old or older
Qualified Individuals 1 (QI-1)**	Eligible for free Medicare Part A (limited funding)	Up to 135% of the Federal Poverty Level*	No Resource Test	20 years old or older

***** The $20.00 General Income Disregard should be added to the level.
****** Cannot be eligible for Medicaid.

Revised July, 2009

Medicare and Travel

An individual's Medicare coverage is available for medical treatment anywhere in the United States. If an individual is away from home and requires medical services, the individual's Medicare card should be presented to the provider of the services. The individual's residential agency is responsible for paying any cost not covered by Medicare unless the medical provider is a New York State Medicaid enrolled provider or is willing to enroll. If the individual has excess assets and would be Medicaid or SSI eligible if the excess assets were spent down, the individual's excess assets might be used for all or part of the medical care bill.

Generally, Medicare does not cover medical services received outside the United States. "Outside the United States" is anywhere that is not one of the 50 states, District of Columbia, or U.S. commonwealth or territories (Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, Swain's Island, and the Northern Mariana Islands).

CMS publishes a pamphlet, "Medicare Coverage Outside the U.S.", (Publication 11037) which provides details about when Medicare will pay. This pamphlet can be found on the Medicare website: www.medicare.gov/publications/pubs/pdf/11037.pdf.

Continuation of Medicare Coverage after the Trial Work Period

After the 9-month Trial Work Period ends, an individual with a disability will continue to receive at least 93 consecutive months of Medicare Part A and Part B coverage. The individual must meet all of the following:

- Continues to work
- Performs substantial gainful activity (SGA)
- Not be medically improved

The 93-month period begins the month after the last month of the person's Trial Work Period.

For more information on the Trial Work Period, see the Work Incentives section of this guide.

How to Appeal a Decision

A Medicare beneficiary has the right to appeal any decision about his or her Medicare services. This is true whether the individual is in the original Medicare plan (Parts A and B) or a Medicare Advantage plan. If Medicare does not pay for an item or service the individual has received, or if the individual does not receive an item or service he or she thinks should be given, he or she can appeal the decision.

Appeal Rights under Original Medicare

If the individual is enrolled in the original Medicare plan, an appeal can be filed if the individual thinks Medicare should have paid for, or did not pay enough for, an item or service he or she received. If an appeal is filed, the individual should ask the doctor or

provider for any information related to the bill that might help the case. The appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to the individual from a company that handles bills for Medicare. The notice will also tell the individual why the bill was not paid and what appeal steps he or she can take.

Appeal Rights under Medicare Managed Care Plans and Medicare Prescription Drug Plans

If the individual is in a Medicare Advantage plan, he or she can file an appeal if the plan will not pay for, does not allow, or stops a service that the individual thinks should be covered or provided. If the individual thinks waiting for a decision about a service could seriously harm his or her health, he or she should ask the plan for a fast decision. In this case, the plan must answer the individual within 72 hours.

The Medicare Advantage plan must tell the individual in writing how to appeal. After the individual files an appeal, the plan will review its decision. Then, if the plan does not decide in the individual's favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See the plan's membership materials or contact the plan for details about the Medicare appeal rights.

When an individual is admitted to a Medicare participating hospital, the hospital gives him or her a copy of "An Important Message from Medicare". If the individual is not given a copy, he or she should ask for it. This brochure explains the individual's rights as a hospital patient, including the following:

- The individual has the right to get all of the hospital care that he or she needs, and any follow-up care after he or she leaves the hospital
- What to do if the individual thinks the hospital is making him or her leave too soon

Medicare has established Quality Improvement Organizations (QIOs) which are groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients in all aspects of Medicare coverage.

If the individual asks a Quality Improvement Organization (QIO) to review his or her case, the individual may be able to stay in the hospital at no charge during the review. The hospital cannot force the individual to leave before the QIO makes a decision.

If the individual has concerns or problems with the plan that are not about payment or service requests, he or she has a right to file a grievance. For example, if the individual believes the plan's hours of operation should be different, he or she can file a grievance.

If the individual has questions about his or her rights or experiences problems that he or she is unable to resolve, the individual or the service coordinator should:

1. Contact the plan directly
2. If the plan cannot or will not resolve the problem, contact 1-800-MEDICARE (1-800-633-4227)
3. If problem still is not resolved, contact CMS to file a complaint:
    - Online: https://www.medicare.gov/MedicareComplaintForm/home.aspx
    - By e-mail: PartDComplaints_RO2@cms.hhs.gov (do not send beneficiary specific information via e-mail)
    - By secure fax: 1-212-264-1022 using the Medicare Part D Complaint Form (see Medicare Part D Complaint Form, page 321).

Supplemental Nutrition Assistance Program

About the Supplemental Nutrition Assistance Program

The federal Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp program, is intended to relieve hunger and malnutrition among low income households by providing a supplemental payment to be used only for food purchases. The program is designed to promote the general welfare and safeguard the health and well-being of the nation's population by raising improving nutrition among low-income households.

Throughout the following section, links to various web pages are provided for reference. Please note that web page addresses change frequently and while the addresses provided were accurate as of the issuance of this Resource Guide, if you unable to access any of the web pages through the links, please refer to the main USDA Food and Nutrition website at www.fns.usda.gov/snap and navigate to the information you are seeking.

Eligibility for the Supplemental Nutrition Assistance Program

An individual residing in certain OPWDD-certified residential settings may be eligible for SNAP benefits if he or she is blind or disabled and in receipt of a disability benefit from a federal or state administered program. He or she must be a citizen of the United States or a legal alien meeting specified criteria. The individual must also have a Social Security number and gross monthly income and resources that do not exceed the applicable limits for the program.

For a disabled or elderly (age 60 or over) individual whose gross income exceeds 200% of the Federal Poverty Level (FPL), the resource limit is $3,250. Within 10 days of any month in which a disabled or elderly household's total income (unearned plus earned income) exceeds 200% of the Federal Poverty Level, such income must be reported. For SNAP budgeting purposes, the FPL amount changes October 1 of every year. Effective October 1, 2013 through September 30, 2014, 200% of the FPL is $1,915.

Applying for SNAP

To apply for SNAP, an individual or his or her representative must file an application with the local Social Services district where the individual resides. The local Social Security office will also accept a SNAP application when the individual is applying for SSI benefits. For people who live alone, the SSI application is also an application for SNAP benefits.

The form needed to apply only for SNAP is the SNAP Benefits Application (LDSS-4826). The publication LDSS-4826-A, How to Complete the SNAP Benefits Application/Recertification, provides assistance for completion of the form. See page 322 for a copy of the SNAP Benefits Application/Recertification form (LDSS-4826) and

page 329 for How to Complete the SNAP Benefits Application/Recertification (LDSS-4826A).

These forms are also available at http://otda.ny.gov/programs/applications/4826.pdf and http://otda.ny.gov/programs/applications/4826A.pdf, respectively.

Documentation

While each SNAP Office handles SNAP applications in their own way, applicants are always required to verify their eligibility. The following is a list of the eligibility factors that must be verified as a condition of eligibility for SNAP benefits and some of the documents that can be used for verification:

IDENTITY: Must be established and documented for the individual making the SNAP application. Any of these documents can also be used to verify age. In addition, the U.S. Passport and Naturalization Certificate can also be used to document citizenship status.

- Birth Certificate
- Photo I.D., Driver's License
- U.S. Passport
- Naturalization Certificate
- Hospital/Doctor's Records
- Adoption Papers

AGE: Must provide verification of age for all individuals applying for SNAP benefits.

- Birth Certificate
- Baptismal Certificate

SOCIAL SECURITY NUMBER: Must provide a social security number or proof that the individual has applied for one. If an applicant knows and lists his/her Social security number on the application, he/she does not need to provide a social security card.

- Social Security Card
- Official correspondence from the Social Security Administration (SSA)

CITIZENSHIP AND ALIEN STATUS: Must be documented for aliens applying for SNAP benefits.

- Birth Certificate
- Hospital Records
- U.S. Passport
- Military Service Records
- Naturalization Papers
- USCIS Documentation

- Evidence of continuous residence in the US since prior to 1/1/72

EARNED INCOME: If individual is employed, the hours worked and amount earned must be documented.

- Current wage stubs (if paid weekly - last 4 paystubs; if paid bi-weekly - last 2 paystubs)
- Pay envelopes
- Letter from employer listing hours worked and hourly or weekly salary
- Current income tax returns
- If self-employed – records and related materials concerning earning and expenses

UNEARNED INCOME: If individual is in receipt of unearned income, the income source and amount must be documented.

- Statement from family court
- Current award letter
- Official correspondence from SSA
- Official correspondence from the Veterans Administration
- Current benefit check or stub
- Statement from bank or credit union
- Statement from person providing support
- Unemployment Income Benefit Statement (UIB)

RESOURCES: ***Documentation is only needed for disabled individuals, or individuals age 60 or older, who have gross income above 200% of the poverty level.*** Households that have an individual that cannot receive SNAP benefits because of a sanction ***are required to verify resources*** if they have any. If the individual has resources but you are not sure whether they must be verified, it is best to provide the verification. This way, if it turns out that the household was required to verify resources, the eligibility decision will not be delayed.

- Current bank or credit union records
- Stock/bond certificate
- Statement from financial institution
- Burial plot agreement or deed
- Property deed and/or appraisal
- Life Insurance
- Vehicle registration/title

Authorized Representatives

An applicant who is not capable of purchasing food, as well as most SNAP recipients in OPWDD residential programs, must have an Authorized Representative (AR). The Authorized Representative (e.g., the Family Care provider for an individual in a Family

Care home or the DDSOO or agency business officer for an individual in a CR/IRA) will receive a separate Electronic Benefit Transfer (EBT) card to access the recipient's SNAP benefit. The Authorized Representative's card, which will be mailed to the AR, has its own unique Personal Identification Number (PIN). When the AR receives the card and the PIN, he or she can choose to change the PIN to a different, personally meaningful number.

SNAP Recertification

One year is the usual certification period for SNAP recipients. Each district may elect, however, to extend the certification period to 24 months for any elderly or disabled individual who has no earned income. Elderly or disabled individuals with earned income may only be certified up to 12 months. Near the end of the certification period, a SNAP recertification form will be sent to the AR for completion.

All SNAP counties participate in telephone recertifications where the counties mail a recertification packet to the individual with a scheduled date and time for a telephone interview. If you are not able to be available during that date & time, you will need to fill out and mail the *Call Time Request Form* found on the last page of the *Notice of Recertification* with the best times and phone number where you may be reached. For recertifications in NYC, you will need to call the number on the *Notice of Recertification* with the best times and phone number where you may be reached. If you have submitted a signed application and miss your scheduled telephone interview, a *Notice of Missed Interview* will be sent to you to reschedule the telephone interview. During the telephone interview, you will be asked some questions based on the SNAP Recertification that you have submitted.

The SNAP program requires that the recipient or AR report certain changes to the local district. Change of address, change in source of income, an increase or decrease in monthly income, and excess resources are some of the changes that need to be reported. The timeframes for reporting are determined by the type of income received. Most changes must be reported within 10 days of the end of the month in which the change occurred.

SNAP Retailer/Point of Sale Terminals

Point of Sale (POS) terminals allow agencies to act as retailers and scan SNAP benefit cards for the individuals that they serve.

Any agency that would like to accept SNAP benefits must apply for a SNAP permit and be licensed to participate in SNAP as a retailer. Information regarding the application process and required documentation can be found online at www.fns.usda.gov/snap/retailers/application-process.htm or by contacting the United States Department of Agriculture (USDA) at 1-877-823-4369.

To become licensed as a retailer and set up a POS terminal, the agency must first file a USDA SNAP Application for Meal Services (FNS-252-2) (call USDA at the number above to request the form) with supporting documentation. A copy of the form can be

found on page 340. Please note: Applications for OPWDD-certified residences cannot be completed online - a paper application must be completed and mailed to USDA at the following address: SNAP Retailer Service Center, USDA – Food and Nutrition Service, P.O. Box 14500, Washington DC 20044. Any questions or inquiries regarding the FNS-252-2 form that was sent should be addressed to USDA at 312-353-6609.

Helpful Websites

The following offer additional useful information regarding SNAP benefits:

US Department of Agriculture (USDA): www.fns.usda.gov

NYS Office of Temporary and Disability Assistance (OTDA): www.otda.ny.gov

NYS Office For People With Developmental Disabilities (OPWDD): www.opwdd.ny.gov

New York City government website: www.nyc.gov

To find out if an individual may be eligible for benefits including SNAP, Temporary Assistance, Special Tax Credits, Home Energy Assistance Program, WIC Program, prescription drug coverage for seniors, and various health insurance programs: www.mybenefits.ny.gov.

To find locations of participating farmer's markets where fresh vegetables and fruit can be purchased with an EBT card: www.snaptomarket.com.

Resource Management

Overview

If an individual's assets are in excess of the Medicaid eligibility level it may be in the individual's best interest to make use of one or more of a number of mechanisms by which funds can be shielded from availability for eligibility purposes.

Management of resources for a person unable to handle those responsibilities himself or herself should ensure that the funds are used to the person's advantage and well being, reflecting the individual's desires and preferences, and ensuring his or her continued receipt of entitlements and benefits. Additionally, appropriate actions must be taken to protect and preserve the resources for the individual's future wants and needs. To assist in this, OPWDD has issued an advisory specifically focused on lump-sum retroactive benefit payments and the actions necessary to the appropriate handling of these funds (see the Additional Resources section, pages 347 and 350.

Four of the mechanisms that may be used to manage resources – trusts, burial funds, burial agreements and life insurance – are discussed in this section.

Trusts

In general, a trust is a legal instrument by which control over the resources of an individual (the beneficiary) is given to another (the trustee) to disburse according to the instructions of the individual or entity creating the trust (the grantor). The determination of the specific type of trust requires evaluation of the age of the individual at the time the trust was created, the source of the trust funds, the relationship of the grantor to the individual, the distribution of remaining trust funds (remainder) upon the beneficiary's death, and the specific language of the trust. Many trusts name additional ("successor") trustees who will be responsible when the original trustee is unable to perform his or her duties. To protect the funds in the trust, the trustee may be required to file a bond. Following are descriptions and rules about some types of trusts relevant to the population served by OPWDD:

Exception Trusts

Exception trusts are trusts that are required to be disregarded as available income and resources in determining Medicaid eligibility pursuant to the provisions of 366(2)(b)(2)(iii) of the Social Services Law and 18 NYCRR 360-4.5(b)(5). Generally, an exception trust established on or after August 11, 1993 is an exempt resource for Medicaid, SSI, and SNAP as long as the trust strictly conforms to the exception trust rules.

Because exception trusts allow beneficiaries to qualify for Medicaid to pay for their medical expenses, agency staff are encouraged to notify families of their existence so that the person's assets do not have to be used to pay for services. If an individual

asking for services is already the beneficiary of a trust, the agency must obtain a copy of the trust to review its provisions and provide a copy to the responsible Medicaid district.

The two types of exception trusts that can be used for the benefit of consumers served by OPWDD are supplemental needs trusts and pooled trusts. They are described below.

Supplemental Needs Trusts[4] (First Party Payback Trusts)

A supplemental needs trust or SNT is a type of exception trust created for the benefit of a disabled person under the age of 65. In order for The New York State Department of Health to consider a supplemental needs trust as a valid type of exception trust, it must:

- Be created with the individual's own assets (i.e., income and/or resources)
- Be created by the disabled person's parent or grandparent, legal guardian of the individual, or by a court of competent jurisdiction – "the grantor"
- Be created prior to the beneficiary's 65th birthday. Once established, additional funds can be added to the trust until the person reaches age 65. However, any additions to the trust made after the person reaches age 65 are treated as a transfer of assets and may invoke the imposition of a penalty period
- Include language specifying that upon the death of the disabled person, the State or the local Medicaid district will receive all amounts remaining in the trust, up to the amount of Medicaid paid out on behalf of the individual (by statute, the State, not the local Medicaid district holds the remainder interest)

Pooled Trusts

A pooled trust is another type of exception trust that may benefit a disabled person. As opposed to a supplemental needs trust, a pooled trust can be created for a disabled person of any age. The main features of a pooled trust are described below:

- The trust is established and managed by a non-profit association per Section 1917(d)(4)(C)(i) of the Social Security Act.
- The assets are pooled with other assets and are managed by a non-profit organization that maintains separate accounts for each person whose assets are included in the pooled trust.

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[4] According to the New York Estates, Powers, and Trusts Law (EPTL) §7-1.12(a)(4) and (5), a "supplemental needs trust" is a "discretionary" trust established for the benefit of a person with a severe and chronic or persistent disability and whose disability is expected to, or does, give rise to long-term need for specialized services. EPTL §7-1.12(b)(3) provides that neither principal nor income held in trust shall be deemed an available resource in determining eligibility under any government benefit or assistance program.

- The disabled individual's account within a pooled trust can be established by the disabled individual (this is not permitted in the case of a supplemental needs trust), by the disabled individual's parent, grandparent, or legal guardian, or by a court of competent jurisdiction.

- The trust will be disregarded for Medicaid purposes regardless of the age of the individual when the pooled trust account is established or when assets are added to the pooled trust account. Be aware there is no exception to the transfer rules for transfers of assets to trusts created for the benefit of persons 65 years of age or older for individuals who receive institutional level services (e.g., nursing home, ICF/DD).

Changes resulting from the Deficit Reduction Act of 2005 in which the penalty period resulting from a transfer of resources at less than fair market value begins on the transfer date or date of application for services, whichever occurs later, has made the placement of assets into a pooled trust an inappropriate vehicle to shield the assets of individuals over 65. This may jeopardize Medicaid eligibility if an individual requires placement into a nursing home, ICF/MR or other medical institution within five years of the transfer.

Under the transfer rules, no transfer penalty is imposed for a compensated transfer (i.e., when the individual has received fair market value in exchange for the assets transferred).

In the case of transfers to a pooled trust after the disabled individual turns age 65, amounts paid out of the pooled trust for the benefit of the disabled individual subsequent to the transfer and prior to the Medicaid eligibility determination for nursing home care must be used to offset all or a portion of the assets transferred to the trust. It is the responsibility of the disabled individual to provide proof of the amounts paid for expenses to meet the needs of the individual during this period.

On the death of the individual funds retained by the non-profit association can be dispersed for the benefit of other beneficiaries.

Other Trusts

In the process of investigating new or ongoing eligibility, you may encounter individuals named as beneficiaries in other trusts, such as non-exception or third party trusts. If a trust is set up in such a way as to negatively affect the individual’s benefits, steps should be taken to convert the trust to one that does not.

Non-Exception Trusts

This kind of trust is created using an individual's own resources but does not exempt those resources in determining Medicaid or SSI eligibility and may therefore prevent the individual from qualifying for Medicaid. An example of a non-exception trust would be a first party trust which does NOT contain the provision that upon the death of the

disabled person, the State or the local Social Services district will receive all amounts remaining in the trust.

These trusts may be either revocable, meaning that individual has the right to terminate the trust, or irrevocable, meaning that the individual may not terminate the trust. There are no restrictions as to who may create a non-exception trust.

Third Party Trusts

A third party trust is established with resources belonging to a person other than the beneficiary of the trust. An individual may be named as the beneficiary of a trust as created by a parent or other party. The most common trust of this type is a testamentary trust in which a parent creates a trust for the benefit of his or her child during the child's lifetime. The trust may or may not be considered an available asset depending on the nature of the trust as defined in the language of the trust instrument which is usually the parent's last will and testament. The remainder interest in this type of trust is specified in the trust instrument and can be any individual (or institution such as a charitable agency) chosen by the person who established the trust.

Establishing a Trust

When a trust is needed to control funds for a disabled person, it is essential that the individual, a family member, advocate, or the agency serving the person find a qualified attorney to help with the process. The assistance of an attorney specializing in elder law or Medicaid regulations is recommended. OPWDD does not provide referrals. A list of practicing attorneys can be obtained through the local county bar association.

Burial Funds

A burial fund is money set aside for a person to meet burial expenses. The money in a burial fund can be used to purchase burial items. Those items do not have to be associated with a funeral home. Burial funds can be in the form of burial contracts and revocable agreements, cash that is identified in a specific account as being held as a burial fund, savings bonds, and any separately identifiable assets that are clearly designated as set aside for the expenses connected with the disposition of the individual's remains after death. It is important that burial funds are kept separate from the individual's other resources. If a burial fund is combined with any funds that are not related to burial expenses it will be considered a countable resource.

In general, an SSI-related individual can have up to $1,500 (or $3,000 for a couple) in assets towards burial expenses, unless a higher amount is authorized through a court order. The $1,500 maximum applies to the combined value of any burial funds, life insurance (with a combined face value greater than $1,500), and non-burial space items included in an irrevocable pre-need funeral agreement. Thus, it is important to understand the value of all three types of accounts collectively to ensure that the individual is within the resource eligibility limits.

In planning for the future, it is important to recognize the wants, needs and preferences of the individual and his or her family in making burial arrangements. Under the rules of

the SSI and Medicaid programs, many individuals may purchase burial space items and set funds aside for burial assets that are excluded. An individual with a burial fund may use money from the burial fund to purchase burial space items. After the purchase, he or she can then begin to add money to the burial fund or create a new one to save for another burial space purchase. This is a way to use extra income and to plan for the future.

If an individual dies without burial space items or burial assets, the person is given a simple burial. For an individual who is enrolled in an OPWDD operated residential program, OPWDD will provide a simple burial. For individuals in other situations, the county provides an indigent's burial, which covers the basic disposition of the body. The typical indigent burial might provide brief calling hours at a funeral home, a basic cloth-covered particleboard casket, and a religious service if desired. Burial would not include a marker.

Irrevocable Pre-Need Burial Agreement

A pre-need burial agreement is a contract in which an individual pays a funeral firm, undertaker, cemetery or other entity to provide certain services or merchandise when the individual dies. This kind of contract is an excellent way of documenting the individual's burial wishes.

Burial agreements can be used to prevent an amount of resources from being considered for Medicaid and SSI eligibility. In order to be considered exempt, burial agreements established after January 1, 1997 must be irrevocable pre-need burial agreements. An irrevocable burial agreement is a pre-payment for services/ merchandise in which the individual takes ownership of the items. There is no limit on the dollar amount of an irrevocable burial agreement and it may be comprised of both burial space items and/or non-burial space items.

NYS DOH defines burial space items as:

> "Burial space items include, but are not limited to: conventional grave sites, crypts, vaults, mausoleums, caskets, urns, or other repositories customarily and traditionally used for the remains of deceased persons. Opening and closing the grave, perpetual care of the gravesite, headstones, and headstone engravings are also considered burial space items."

All items not determined burial space items by the definition above are considered non-burial space items, including any funds indicated for miscellaneous expenses.

A Medicaid recipient whose receipt of Medicaid began prior to January 1, 1997 and who had a revocable pre-need funeral agreement in place that was considered exempt, may either maintain the revocable agreement or establish an irrevocable agreement.

A person who did not have Medicaid eligibility authorized prior to January 1, 1997 and who has a revocable funeral agreement for more than $1,500 must convert the

agreement to an irrevocable pre-need funeral agreement in order to have the entire agreement disregarded as a resource for Medicaid.

Establishing an Irrevocable Pre-Need Burial Agreement

There is no prescribed form used when establishing an irrevocable burial agreement, but the document must contain the following paragraph:

"New York Law requires this agreement to be irrevocable for applicants for receipt of Supplemental Security Income 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. 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."[5]

Life Insurance

A life insurance policy is a contract between an individual and an insurance company. There are several types of life insurance policies available to a person: ordinary, limited, endowment, and term.

The face value of a life insurance policy is the basic death benefit or maturity amount of the policy that is specified on its first page. The face amount does not include dividends, additional amounts payable because of accidental death, or other special provisions. The face amount is that amount paid upon the death of the insured.

The cash surrender amount of the policy is the amount that the insurer will pay upon cancellation of the policy before death or maturity. This value usually increases with the age of the policy although loans against the policy may decrease its cash value.

The basic types of life insurance are defined as follows:

- **Ordinary** (Whole Life) – The insured pays premiums during his or her lifetime (straight life) or until the age of 100 (unless purchased by a single premium or by letting dividends accumulate). Upon the death of the insured, the insurance company pays the higher of either the face value of the policy or the cash amount of the policy to the beneficiary. This type of insurance usually has a cash surrender value after the second year. The policy is flexible in premium payments. Dividends may be used to pay off the contract at an earlier date, or

[5]A Medicaid recipient whose receipt of Medicaid began prior to January 1, 1997 and who had a revocable pre-need funeral agreement in place, which was considered exempt, may either maintain the revocable agreement or establish an irrevocable agreement.

A person who has Medicaid eligibility established after January 1, 1997 and who has a revocable funeral agreement with more than $1,500 must convert the agreement to an irrevocable pre-need funeral agreement in order to have the entire agreement disregarded as an available resource.

the premium payment period can be limited to suit the financial resources of the insured. In this situation, the policy is a limited payment life insurance policy.

- **Limited Payment** – Similar to ordinary life, but the premiums are higher while the period of payment may be reduced. The result is a larger cash reserve than whole life.

- **Endowment** – The face value is payable after the time period for payment of the premiums has expired, or when the insured dies.

- **Term** – A contract of temporary protection. The insured pays relatively small premiums for a limited number of years. The insurance company agrees to pay the face amount of the policy only if the insured dies within the time specified in the policy. Generally, term insurance does not have a cash surrender value; however, some newer types have a cash value.

If an individual has a Life Insurance Policy, it may affect benefit eligibility as follows:

If a person has one or more life insurance policies and the face[6] values of those policies total $1,500 or less, he or she can supplement the life insurance with an exempt burial fund. The amount of the exempt burial fund is limited to an amount that, when added to the combined face values of the life insurance policies, totals no more than $1,500. Interest accumulated on an exempt burial fund is also an exempt resource.

When the combined face values of life insurance policies exceed $1,500, the cash values are considered countable resources for determining benefit eligibility. If both the face value and the cash value[7] of a life insurance policy exceed $1,500, only $1,500 of the total cash value is considered exempt as a burial fund. In order for the cash value of $1,500 to be exempt, the individual must designate in writing the entire cash value as a burial fund. If the individual does not provide a written statement to the local Medicaid district, the $1,500 is not considered an exempt resource.

Medicaid Transfer of Assets

For Medicaid purposes, a transfer of assets is defined as a voluntary assignment or transfer of non-exempt assets for less than the fair market value of those assets. A voluntary transfer of assets for less than the fair market value is prohibited when it is made up to 60 months prior to the date the individual applies for Medicaid or at any time after that date.

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[6] The face value of a life insurance policy is the basic death benefit or maturity amount of the policy that is specified on its first page. The face amount does not include dividends, additional amounts payable because of accidental death, or other special provisions

[7] The cash value of the policy is the amount that the insurer will pay upon cancellation of the policy before death or maturity. This value usually increases with the age of the policy although loans against the policy may decrease its cash value.

The Deficit Reduction Act of 2005 changed certain rules regarding the look-back period for transfers of assets:

- The look-back period will increase in one-month increments beginning February 1, 2009 up to a 60-month look-back.

- The asset transfer rules have changed from a 36-month look-back period up to a 60-month look-back for all persons requesting nursing facility level of care as described above.

Effective 9/24/2007, transfer provisions do not apply to persons applying for or receiving Waiver services.

The transfer of assets rules do not apply to persons whose Medicaid eligibility is determined without a resource test, for example, pregnant women.

Medicaid Transfer Penalty

When a Medicaid applicant has made a prohibited transfer but is otherwise eligible for Medicaid, a penalty period is imposed. During this penalty period, the applicant is not eligible for the following care and services:

- Nursing facility services
- Intermediate Care Facility services
- A level of care provided in a hospital equivalent to nursing facility services

A penalty period is not imposed on transfers made by individuals applying for or receiving Waiver services. In addition, review up to a 60-month look-back is no longer required for Waiver participants.

The penalty period begins with the first of the month following the month in which the assets were transferred or the date the person is receiving nursing facility services, whichever is later. The length of the penalty period is the number of months calculated by dividing the total uncompensated value of the transferred assets by the average regional rate for the nursing facility services in the region where the individual is institutionalized. If the uncompensated value of the transferred assets is less than the regional rate or if the penalty period results in a partial month penalty, the uncompensated value is counted as part of the individual's Net Available Monthly Income (NAMI).

Additional Resources

This Guide has been designed to help you develop the benefits and entitlements necessary to fund OPWDD and other services for individuals served by voluntary agencies. It is intended to support you in assisting and qualifying the individuals in your care for benefits, however it is not intended to answer every question that you may have or deal with every situation you may encounter.

Additional Information and Assistance

For additional information and assistance, please contact your local Revenue Support Field Office. A list of offices including service areas and contact information can be found beginning on page 156. Training opportunities can be found on the OPWDD website: www.opwdd.ny.gov.

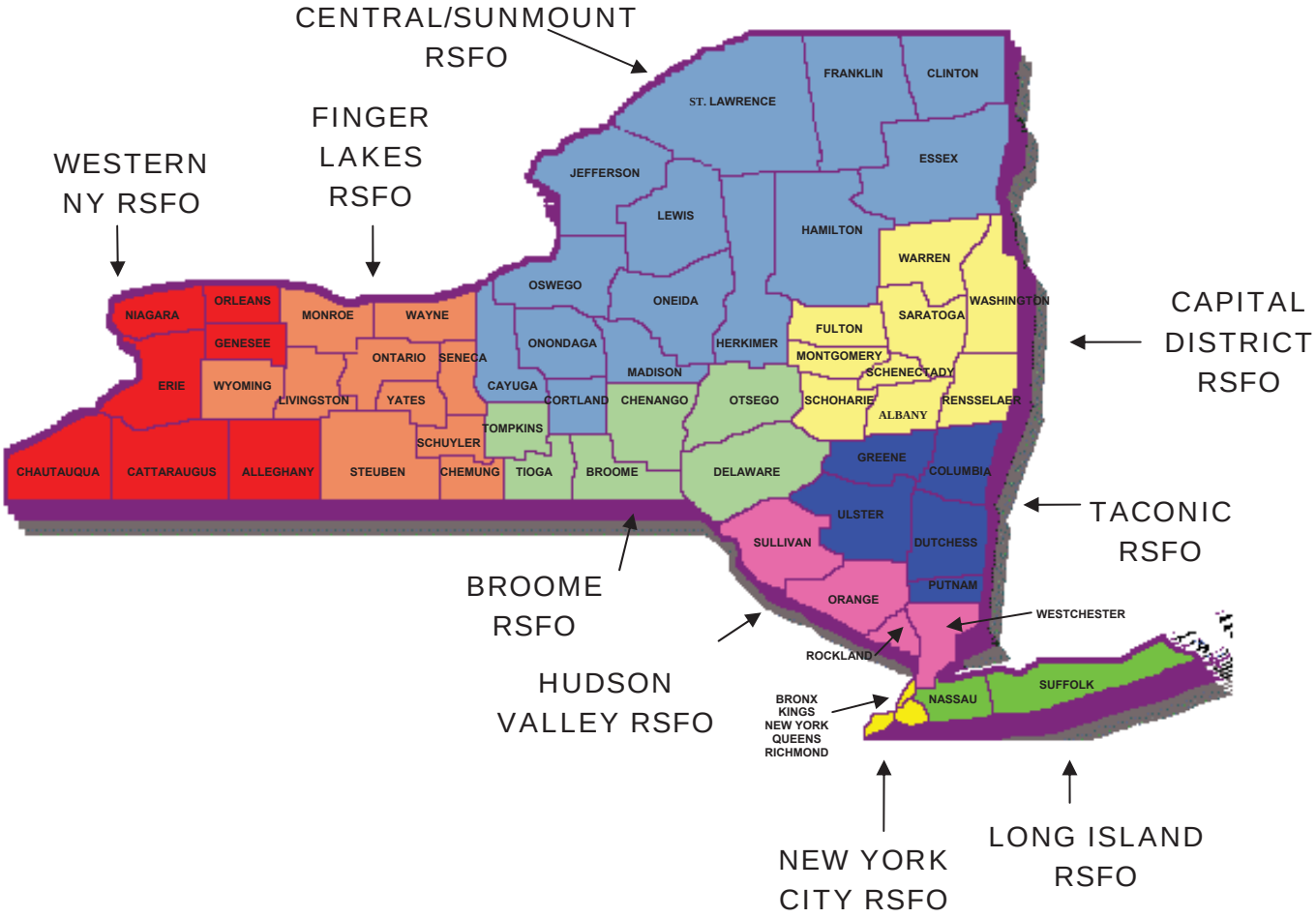
Attachments

As you look through the body of this Guide, you will notice that each benefit section includes references to a large number of additional resources in the form of attachments. These attachments can be found on the pages that follow. They consist of documents containing sample forms and other information.

Note: Forms included as attachments are provided as samples for reference only. It is important that benefits personnel obtain and use the most current versions of all forms. Current forms may be obtained by contacting the benefit-paying agency. A list of Local Departments of Social Services and their contact information can be found on page 185 of the attachments that follow.

To locate the Social Security office that serves your area, a local office search by zip code can be done on the Social Security Administration website (www.ssa.gov or www.socialsecurity.gov). Many of the forms may be also be accessed online.

REVENUE SUPPORT FIELD OFFICES
SERVICE AREAS



RSFO/Address/Phone/Fax	Service Area
BROOME RSFO 229-231 State Street – 3rd Floor Binghamton, NY 13901 **Phone: (607) 771-7210** Fax: (607) 771-1098	**Broome DDSOO** For the counties of: Broome, Chenango, Delaware, Otsego, Tioga, Tompkins
CAPITAL DISTRICT RSFO Capital District DDSOO, Bldg. 12-A Oswald D. Heck Developmental Center 500 Balltown Road Schenectady, NY 12304 **Phone: (518) 370-2010** Fax: (518) 370-2297	**Capital District DDSOO** For the counties of: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
CENTRAL/SUNMOUNT RSFO 101 West Liberty Street P.O. Box 388 Rome, NY 13442 **Phone: (315) 339-3440** Fax: (315) 336-0407	**Sunmount DDSOO** **Central New York DDSOO** For the counties of: Cayuga, Clinton, Cortland, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence
FINGER LAKES RSFO Vienna Building, Room 137 509 Vienna Street Newark, NY 14513 **Phone: (315) 331-7141** Fax: (315) 331-0182	**Finger Lakes DDSOO** For the counties of: Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates

RSFO/Address/Phone/Fax	Service Area
HUDSON VALLEY RSFO P.O. Box 470 3 Wilbur Road Thiells, NY 10984 **Phone: (845) 947-6250** Fax: (845) 947-6161	**Hudson Valley DDSOO** For the counties of: Orange Sullivan Rockland Westchester
LONG ISLAND RSFO 415A Oser Avenue Hauppauge, NY 11788 **Phone: (631) 434-6109** Fax: (631) 434-6511	**Long Island DDSOO** For the counties of: Nassau Suffolk
NEW YORK CITY RSFO 25 Beaver Street – 3rd Floor New York, NY 10004-2310 **Phone: (646)766-3472** Fax: (646)766-3474	**Metro New York DDSOO** **B. Fineson DDSOO** **Brooklyn DDSOO** **Staten Island DDSOO** **Institute Basic Research** For the counties of: Bronx Queens Kings Richmond Manhattan
TACONIC RSFO 36 Firemen's Way Poughkeepsie, NY 12603-6519 **Phone: (845) 473-8210** Fax: (845) 473-8204	**Taconic DDSOO** For the counties of: Columbia Putnam Dutchess Ulster Greene
WESTERN NEW YORK RSFO 1200 East & West Road Building 16-4W West Seneca, NY 14224 **Phone: (716) 675-8666** Fax: (716) 675-8919	**Western New York DDSOO** For the counties of: Allegany Genesee Cattaraugus Niagara Chautauqua Orleans Erie

Updated 7/14/14

2014 BENEFIT AND RATE LEVELS – EFFECTIVE JANUARY 2014

SSI Level	**Individual**	**Couple**
Resources	$2,000.00	$3,000.00
Medicaid Levels	**Household of One**	**Household of Two**
Income	$808.00	$1,186.00
Assets	$14,550.00	$21,450.00
Medicaid Buy-In for Working People with Disabilities (MBI-WPD)	**Household of One**	**Household of Two**
150% of Federal Poverty Level	$1,459.00	$1,967.00
250% of Federal Poverty Level	$2,332.00	$3,278.00
Resource Level	$20,000.00	$30,000.00
Family Care Levels *(Congregate Care I)*	**Individual**	**Couple**
NYC/Westchester/Suffolk/Nassau/Rockland	$987.48	$1,974.96
Rest of State	$949.48	$1,898.96
IRA/Community Residence Level *(Congregate Care II)*	**Individual**	**Couple**
NYC/Westchester/Suffolk/Nassau/Rockland	$1,156.00	$2,312.00
Rest of State	$1,126.00	$2,252.00
Federal Benefit Level	$721.00	$1,082.00
Personal Needs Allowance		
ICF	$35.00	
Family Care	$139.00	
IRA/Community Residence	$160.00	
Medicare Part A Monthly Premium		
With < 30 Quarters of Coverage	$426.00	
With 30 to 39 Quarters of Coverage	$234.00	
Medicare Part B Monthly Premium	$104.90	
Substantial Gainful Activity (SGA) Level	$1,070.00	
Medicare Savings Program (MSP) Income Levels		
Qualified Medicare Beneficiary (QMB) $973.00 (100% FPL) + $20.00 (General Income Disregard)	$993.00*	
Specified Low Income Medicare Beneficiary (SLIMB) $1,167.00 (120% FPL) + $20.00 (General Income Disregard)	$1,187.00*	
Supplemental Nutrition Assistance Program (SNAP) Resource Level for a disabled or elderly Individual with gross income > 200% FPL *($1,915 per month for October 2013 – September 2014; $1,945 per month for October 2014 – September 2015)*	$3,250.00	

* No resource test for MSP unless individual also has Medicaid; in that case, Medicaid resource level applies.

BENEFIT ELIGIBILITY QUESTIONNAIRE

A. INFORMATION ABOUT THE INDIVIDUAL

Full Name at Birth	Date of Birth	Social Security Number
Place of Birth (City, State) (attach a copy of the individual's birth certificate)		U.S. Veteran? ☐ YES ☐ NO

Marital Status	Spouse's Name	Date and Place of Marriage/Divorce

U.S. Citizen ☐ YES ☐ NO
If NO, please provide the individual's alien registration number, the date of entry, and the port of entry. Please attach a copy of both sides of the individual's Alien Registration Card or Permanent Resident Card and any other proof of lawful residence.

Is there a **court appointed** legal guardian, alternate or standby guardian, conservator, or committee for the individual?
☐ YES ☐ NO If YES, give the name and address (attach copies of the legal papers):

If the individual is under age 21, does he/she live with his/her parents? ☐ YES ☐ NO

Is the individual covered by Medicaid? ☐ YES ☐ NO

If YES: Client Identification Number (CIN):_____ Date approved:_____

If NO: Was a Medicaid application filed? ☐ YES ☐ NO If YES, complete the following:

Date of application: _____ Date of denial: _____

Reason for denial: _____

Is the individual enrolled in the HCBS Waiver? ☐ YES ☐ NO Enrollment Date:_____

If NO: Has a HCBS Waiver application been filed for the individual? ☐ YES ☐ NO

Date of application: _____ Date of denial: _____

Reason for denial: _____

What services is the individual receiving? *Include **all services** provided by your agency and any other agency:*

B. INFORMATION ABOUT THE INDIVIDUAL'S INCOME

Does the individual receive income from any source? ☐ YES ☐ NO
If YES, complete the following regarding all sources of income the individual received during the last 3 months:

Income Source	Who is Payee?	Claim Number	Monthly Amount
SOCIAL SECURITY			$
SUPPLEMENTAL SECURITY INCOME (SSI)			$
Other Benefits			$
			$

Was the individual ever employed or did he or she receive wages (including wages from a workshop)? ☐ YES ☐ NO
If YES, is the individual currently employed? ☐ YES ☐ NO
If YES, complete the following about the current employer(s), other employers, and monthly gross wages during the last 3 months.

Employer(s)	Address	Gross Wages

C. INFORMATION ABOUT THE INDIVIDUAL'S ASSETS

Answer the following question only if the individual will be residing in an ICF:
Has the individual sold, given away or transferred any cash, real estate, or other asset(s) during the last 60 months?
☐ YES ☐NO
If YES, attach a sheet with details, including the type of asset, value, to whom the asset was sold/given/transferred, the date of the transaction and the amount for which the asset was sold.

Has the individual placed any asset(s) into a trust or have any disbursements been made from a trust established for the individual's benefit?
☐ YES ☐ NO
If YES, attach a photocopy of the trust document or a sheet with details about the trust, including the source of the money, the name of the trustee, location of the trust, account number and the value of the trust.

Does the individual have any bank account(s), credit union account(s), certificates of deposit, annuity, 401(k), other retirement account, stocks, bonds, securities, or interest in real property?
☐ YES ☐ NO
If YES, attach copies (attach an additional sheet if needed for additional assets or details):

	Asset 1	Asset 2
Type of Asset		
Name of Person Receiving Bank Statements or Holding Records		
Current Asset Value		

Is there a burial fund for the individual? ☐ YES ☐ NO If YES, attach a sheet with details.

Does the individual have a pre-need funeral contract, a burial trust, a burial plot or other burial space items?
☐ YES ☐ NO If YES, provide details (attach a photocopy of the contract):

D. FUTURE INCOME OR ASSETS FOR THE INDIVIDUAL

Does the individual have an interest in, possible interest in, or expect to receive an inheritance, lawsuit settlement, trust fund or other asset? ☐ YES ☐ NO
If YES, describe the asset below (attach a sheet with details).

E. INFORMATION ABOUT THE INDIVIDUAL'S LIFE INSURANCE

Is there Life Insurance on the individual? ☐ YES ☐ NO If YES, complete the following:

Insurance Company Name and Address

Policy Number(s)	Face Value $

Name and Address of the Person Holding the Policy

F. INFORMATION ABOUT THE INDIVIDUAL'S HEALTH INSURANCE

Does the individual have Medicare? ☐ YES ☐ NO	Effective Date	Claim Number
Part A Hospital Insurance ☐ YES ☐ NO		
Part B Medical Insurance ☐ YES ☐ NO		
Part D Prescription Drug Plan ☐ YES ☐ NO		
Medicare Advantage Plan ☐ YES ☐ NO		

Medicare Advantage Plan Name, Address and Phone Number		
Is the individual covered by other health insurance? ☐ YES ☐ NO If YES, please enclose a copy of the insurance certificate, policy, booklet or card (front and back) and complete the following:		
Insurance Company Name and Address		
Policy Number	Group Number	Other Identifier(s)
Effective Date of Coverage	Subscriber's Name	
Name and Address of Group/Employer		

G. IDENTIFYING INFORMATION ABOUT THE INDIVIDUAL'S PARENTS and SPOUSE

	FATHER	MOTHER	SPOUSE
Full Name at Birth/Maiden Name			
Date of Birth			
Place of Birth (City, State)			
Social Security Number			
U. S. Citizen	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
U. S. Veteran If YES, provide:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Serial Number			
Claim Number			
Receiving Disability/Retirement Benefit	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Date of Disability/Retirement			
Date and Place of Death, if applicable			

H. FINANCIAL REPRESENTATIVES FOR THE INDIVIDUAL

Is there any other person(s) who has financial information about the individual? ☐ YES ☐ NO
If YES, provide the information below or attach a sheet with a detailed list:

NAME	ADDRESS AND PHONE NUMBER	RELATIONSHIP

I. THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of Person Completing Form	Print Name	
Relationship to Individual	Telephone	Date

INSTRUCTIONS FOR COMPLETING THE BENEFIT ELIGIBILITY QUESTIONNAIRE

A. INFORMATION ABOUT THE INDIVIDUAL

Full Name at Birth: Enter the applicant's full name.

Date of Birth: Enter the applicant's date of birth. Please attach a photocopy of the individual's birth certificate.

Social Security Number: Enter the applicant's Social Security number.

Place of Birth: Enter the applicant's place of birth.

U.S. Veteran: Indicate whether the applicant is a U.S. Veteran by placing a check mark in front of either **YES** or **NO**.

Marital Status: Indicate the applicant's marital status by writing "Single", "Married", "Divorced", or "Widowed".

Spouse's Name: Write the name of the applicant's spouse, if applicable.

Date and Place of Marriage/Divorce: Indicate the city and state in which the applicant was married/divorced.

U.S. Citizen: If the applicant is a U.S. Citizen, place a check mark in front of **YES**; if the applicant is not a U.S. Citizen, place a check mark in front of **NO**. If No is checked, please provide an explanation of the applicant's status. If applicable, please provide the applicant's alien registration number, the date and port of entry, and attach a copy of both sides of the individual's Alien Registration Card or Permanent Resident Card and any other proof of lawful residence.

Is there a court appointed legal guardian, alternate or standby guardian, conservator or committee for the individual? If yes, place a check mark in front of **YES**, write the name and address of the individual, and attach copies of the legal papers.

If under age 21, is the person living at home with his or her parents? If the applicant is under 21 years old and lives at home with his or her parents, place a check mark on the line in front of **YES**. Please provide proof of the applicant's residence such as a statement from a landlord, current rent receipt or lease, mortgage records, school records, current mail or a statement from another person.

If the applicant is under 21 years old, but does not live at home with his or her parents, place a check mark in front of **NO**.
If the applicant is 22 years old or older, do not answer this question.

Is the individual covered by Medicaid? If the applicant named currently has Medicaid, place a check mark in front of **YES**.

- **Client Identification Number (CIN):** The CIN is the same as the Medicaid Number – if the local Department of Social Services (DSS) or the New York City Human Resources Administration (HRA) assigned a Medicaid number to the person, enter the number. A Medicaid number consists of eight characters: two letters, followed by five numbers and then one letter, such as AB12345C. This number will appear on the person's Medicaid card.
- **Date Approved:** Enter the date that the Medicaid application was approved by the local Department of Social Services (DSS) or the New York City Human Resources Administration (HRA).

If the applicant does not have Medicaid place a check mark on the line in front of **NO.**

Was a Medicaid application filed? If the applicant has had a Medicaid application filed, place a check mark on the line in front of **YES**.

- **Date of Application:** Enter the date that the Medicaid application was filed with the local Department of Social Services (DSS) or the New York City Human Resources Administration (HRA).
- **Date of Denial:** If the Medicaid application was denied, enter the date that the Medicaid application was denied by the local DSS/HRA
- **Reason for Denial:** Enter the reason that the local DSS/HRA provided when they denied the application. If a denial notice was received, please attach a copy of the notice to this form.

Is the individual enrolled in the Home and Community Based Waiver (HCBS) Waiver? If the applicant currently is enrolled in the HCBS Waiver, place a check mark in front of **YES**.

- **Enrollment Date:** Enter the date that the person named enrolled in the HCBS Waiver program through the local DDSO (Developmental Disabilities Services Office)/NYCRO (New York City Regional Office).

If the applicant is not currently enrolled in the HCBS Waiver, place a check mark in front of **NO**.

Has an HCBS Waiver application been filed? If an application for an HCBS Waiver was filed by any agency for the person, place a check mark in front of **YES**. Then provide the following information:

- **Date of Waiver application:** Enter the date that the HCBS Waiver application was filed with the local DDSO/SDIS.
- **Date of Denial:** If the HCBS Waiver application was denied by the local DDSO/NYCRO, enter the date that the application was denied.
- **Reason for Denial**: Enter the reason that the local DDSO/NYCRO provided when they denied the application. If a denial notice was received please attach a copy of the notice.

What services is the individual receiving? List all of the services the individual is receiving, whether by your agency or any other agency.

B. INFORMATION ABOUT THE INDIVIDUAL'S INCOME

Does the individual receive income from any source? If the applicant receives income, place a check mark in front of **YES**.

- **Income Source:** List sources of income such as Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI) or Other Benefits (Railroad Retirement (RRB), Child Support or other benefits paid to a person that they do not perform work to receive).
- **Who is Payee?** A payee is the person who receives the funds. The applicant may be payee for their own benefits or a family member or other trusted adult may receive the funds.
- **Claim Number:** Enter the SSA/SSI or Other Claim Number associated with the benefit check.
- **Monthly Amount:** Enter the monthly benefit amount received.

Was the individual ever employed or did he or she receive wages (including wages from a workshop)? If the applicant has ever worked, place a check mark in front of **YES**.

- **If Yes, is the individual currently employed?** If so, place a check mark in front of **YES**.
- **If Yes, complete the following about the current employer(s), other employers, and monthly gross wages during the last 3 months:** List the employer, employer's address, and monthly gross wages during the last 3 months on the line provided. If more than one employer, attach a separate sheet.

If the applicant is not currently employed, place a check mark in front of **NO**.

C. INFORMATION ABOUT THE INDIVIDUAL'S ASSETS

Has the individual sold, given away or transferred any cash, real estate, or other asset(s) during the last 60 months? *This question is to be answered only if the applicant will be residing in an ICF; otherwise, skip to the next question.*
If the applicant has sold, given away or transferred any cash, real estate or other assets in the last 60 months, place a check mark in front of **YES**. Attach a sheet listing the type of asset, value, to whom the asset was sold/given/transferred, the date of the transaction and the amount for which the asset was sold. If the applicant has not sold, given away or transferred any cash, real estate or other assets in the last 60 months place a check mark in front of **NO.**

Has the individual placed any asset(s) into a trust or have any disbursements been made from a trust established for the individual's benefit? If the applicant is the beneficiary of a trust or has placed any asset(s) into a trust, place a check mark in front of **YES**. Please attach a photocopy of the trust document or a sheet detailing the trust, including where the money came from, the name of the trustee, where the trust is located, the account number of the trust, and the value of the trust. If the applicant has not placed any asset(s) into a trust and is not the beneficiary of a trust, place a check mark in front of **NO.**

Does the individual have any bank account(s), credit union account(s), certificates of deposit, annuity, 401(k), other retirement account, stocks, bonds, securities, or interest in real property? If so, place a check mark in front of **YES**. In the space provided, enter information about all asset(s) owned by the applicant.

- **Type of asset.** Enter the type of asset(s) owned by the applicant. Examples of an asset include savings and checking accounts at a bank or credit union, trust accounts, 401(k) accounts, stocks, bonds or certificates of deposit.
- **Name of Person Receiving Bank Statements or Holding Records.** Enter the name on the account.
- **Current Asset Value.** Enter the current value of each asset.

Is there a burial fund for the individual? If the applicant owns a burial fund, place a check mark in front of **YES** and attach a photocopy of the account information, or list the name and address of where the money is, account number and amount of the burial fund. If the applicant does not have a burial fund, place a check mark in front of **NO.**

Does the individual have a pre-need funeral contract, a burial trust, a burial plot or other burial space items? If the applicant has one or more of these items, place a check mark in front of **YES** and attach a photocopy of the pre-need contract, trust or plot. If that is not available, list the name and address of where the contract is held, account number and amount of the burial fund item(s). If the applicant does not have a burial fund, place a check mark in front of **NO.**

D. FUTURE INCOME OR ASSETS FOR THE INDIVIDUAL

Does the individual have an interest in, possible interest in, or expect to receive an inheritance, lawsuit settlement, trust fund or other asset? If the applicant is expected to be beneficiary of a trust or if the person will be receiving a large amount of money in the future, place a check mark in front of **YES**. Please attach a photocopy of any legal papers pertaining to this asset or a sheet detailing the situation. If the applicant is not expected to receive any future money, place a check mark in front of **NO.**

E. INFORMATION ABOUT THE INDIVIDUAL'S LIFE INSURANCE

Is there Life Insurance on the individual? If the person owns a life insurance policy, place a check mark in front of **YES**. Then:

- Enter the Insurance Company Name(s) and Address(es)
- Enter the policy number(s)
- Enter the Face Value of the policy (face value is the basic death benefit or maturity amount of the policy that is specified on its first page)
- Enter the name and address of the person holding the policy if the applicant is not the one holding the policy.

F. INFORMATION ABOUT THE INDIVIDUAL'S HEALTH INSURANCE

Does the individual have Medicare? If the applicant is covered by Medicare, place a check mark in front of **YES**.

Part A Hospital Insurance: If the applicant has Medicare Part A, place a check mark in front of **YES**.

- **Effective Date:** Enter the date that Medicare Part A started.
- **Claim Number:** Enter the Medicare number that shows on the Medicare Card.

Part B Medical Insurance: If the applicant has Medicare Part B, place a check mark in front of **YES.**

- **Effective Date:** Enter the date that Medicare Part B started.
- **Claim Number:** Enter the Medicare number that shows on the Medicare Card.

Part D Prescription Drug Plan: If the applicant has Medicare Part D, place a check mark in front of **YES**.

- **Effective Date:** Enter the date that Medicare Part D started.
- **Claim Number:** Enter the Medicare number that shows on the Medicare Prescription Card.

Medicare Advantage Plan: If the applicant is enrolled in a Medicare Advantage Plan, place a check mark in front of **YES.**

- **Effective Date:** Enter the date that Medicare Advantage Plan started.
- **Claim Number:** Enter the Medicare Advantage Plan number that shows on the insurance card.
- **Information about the Medicare Advantage Plan:** List the name, phone number and address of the Medicare Advantage Plan.

If the applicant is not covered by Medicare, place a check mark in front of **NO**.

Is the individual covered by other health insurance? If the applicant has health insurance coverage, place a check mark in front of **YES**.

- **Insurance Company Name and Address:** Enter the name of the applicant's health insurance company and the company's address.

- **Policy Number:** Enter the policy number that shows on the applicant's insurance card.
- **Group Number:** Enter the group number that shows on the applicant's insurance card.
- **Other Identifier(s):** Enter any other number that might be associated with the applicant's insurance.
- **Effective Date of Coverage:** Enter the date that the insurance coverage first started for the applicant.
- **Subscriber's Name:** Enter the name of the primary person who has the insurance.
- **Name and Address of Group/Employer:** If the health insurance coverage is through a group plan, list the name and address of the group or employer. If coverage is not through a group or employer, leave this space blank.

G. IDENTIFYING INFORMATION ABOUT THE INDIVIDUAL'S PARENTS AND SPOUSE

Full Name at Birth/Maiden Name: Enter the father's name, mother's maiden name, and spouse's name in the appropriate columns.

Date of Birth: Enter the date of birth of the father, mother, and spouse in the appropriate columns.

Place of Birth (City, State): Enter the city and state in which the father, mother, and spouse were born in the appropriate columns.

Social Security Number: Enter the father's, mother's, and spouse's social security numbers in the appropriate columns.

U.S. Citizen: If the father, mother, or spouse is a U.S. Citizen, place a check mark in front of **YES** in the appropriate column(s). If the father, mother, or spouse is not a U.S. Citizen, place a check mark in front of **NO** in the appropriate column(s).
U.S. Veteran: If the father, mother, or spouse is a U.S. Veteran, place a check mark in front of **YES** in the appropriate column(s).

- **Serial Number:** Enter the Veterans Association (VA) Serial Number for the father, mother, and/or spouse that is a U.S. Veteran.
- **Claim Number:** Enter the Claim Number for VA Benefits for the father, mother, and/or spouse that is a U.S. Veteran.

If the father, mother, or spouse is not a U.S. Veteran, place a check mark in front of **NO** in the appropriate column(s).

Receiving Disability/Retirement Benefit: If the father, mother, or spouse is receiving disability or retirement benefits, place a check mark in front of **YES** in the appropriate column(s). If the father, mother, or spouse is not receiving disability or retirement benefits, place a check mark in front of **NO** in the appropriate column(s).

Date of Disability/Retirement: If the father, mother, or spouse is disabled or retired, enter the date that the disability or retirement started in the appropriate column(s).

Date and Place of Death, if applicable: If the father, mother, or spouse is deceased, enter the date(s) of death in the appropriate column(s).

H. FINANCIAL REPRESENTATIVES FOR THE INDIVIDUAL

Is there any other person(s) who has financial information about the individual? If an individual is known to have financial information about the applicant for benefits, place a check mark in front of **YES.** Enter the individual's name, address and relationship to the applicant for each person who has financial information about the applicant. If there is no other person known to have financial information regarding the applicant, place a check mark before the **NO**.

The information provided is correct to the best of my knowledge. The person completing the financial investigative form should sign the form, print their name, indicate their relationship to the applicant, and provide their telephone number and the date the form was completed.

IDENTITY and CITIZENSHIP OR IMMIGRATION STATUS FOR THE MEDICAL ASSISTANCE PROGRAM

For the Medical Assistance Program, identity and United States (U.S.) citizenship or satisfactory immigration status must be documented. If you declared U.S. Citizenship, we were unable to verify your declaration, therefore, we are providing the list below which contains acceptable documents that support proof of identity, U.S. citizenship status. All documents must be originals or copies certified by the issuing agency. For the purposes of qualifying as a U.S. citizen, the U.S. includes the 50 states, the District of Columbia, American Samoa, Swain's Island and, if born on or after certain dates, Puerto Rico, Guam, the U.S. Virgin Islands and the Northern Mariana Islands.

Documents which Establish both Citizenship and Identity

- U.S. passport book/card;
- Certificate of Naturalization (N-550 or N-570);
- Certificate of U.S. Citizenship (N-560 or N-561);
- New York State Enhanced Driver License (EDL)/non-driver ID;
- Native American Tribal document (issued by a federally recognized tribe); or
- Certificate of Degree of Indian Blood, or other U.S. Native American/Alaska native tribal document with photo or other identifying information.

Secondary Documents which Establish Citizenship but also require one identity document from the Identity Documentation list

- U.S. Birth Certificate showing birth in one of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 1/13/1941), Virgin Islands of the U.S. (on or after 1/17/1917), Northern Mariana Islands (NMI) (after 11/4/1986 [NMI local time]), or Guam (on or after 4/10/1899);
- Certification of Report of Birth issued by the Department of State (DS-1350);
- Report of Birth Abroad of a U.S. Citizen (FS-240);
- Certification of birth issued by Department of State (Forms FS-545 or DS-1350);
- U.S. Citizen Identification Card (I-197 or I-179);
- Northern Mariana Identification Card (I-873);
- American Indian Card with classification code of "KIC" (I-872);
- Final adoption decree showing U.S. place of birth;
- Evidence of U.S. civil service employment before 6/1/1976;
- Military record of service showing U.S. place of birth (i.e., DD-214); or
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.

Third Level Documents which Establish Citizenship but are less reliable than Secondary Documents (Also requires an identity document)

- Extract of hospital record on hospital letterhead. The record must have been established at the time of birth and the extract must have been created at least five years before the Medicaid application date (or, for children younger than 16 years of age, near the time of birth) and must show a U.S. place of birth;
- Life, health or other insurance record, if it shows a U.S. place of birth and was created at least five years prior to the application date (or, for children younger than 16 years of age, near the time of birth);
- Religious record recorded in the U.S. within three months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made; or
- Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents.

Fourth Level Documents which Establish Citizenship but are the least reliable and should only be used in rarest of circumstances (Also requires an identity document)

- Federal or State census record showing U.S. citizenship or a U.S place of birth; or
- The following other documents are acceptable if they indicate a U.S. place of birth and were created at least five years prior to the application date (or, for children younger than 16 years of age, near the time of birth):
  - Medical (clinic, doctor, or hospital) record;
  - Seneca Indian tribal census;
  - Bureau of Indian Affairs tribal census records of the Navajo Indians;
  - U.S. State Vital Statistics official notification of birth registration;
  - Delayed U.S. public birth record that is recorded more than five years after the person's birth;
  - Statement signed by the physician/midwife who was in attendance at the time of birth; or
  - Bureau of Indian Affairs Roll of Alaska Natives; or
- Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least five years before the application date) showing a U.S. place of birth; or
- Written affidavit (to be used only in rare instances).

Documents which Establish Identity

- A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. Canadian driver's licenses may not be used;
- School identification card with a photograph of the individual;
- U.S. military card or draft record;
- Identification card issued by federal, State, or local government with the same information included on the driver's license;
- Military dependent's identification card;
- U.S. Coast Guard Merchant Mariner card;
- A cross-match with a federal or State governmental, public assistance, law enforcement, or corrections agency's data system;
- If none of the above identity documents is available, a combination of three or more corroborating documents such as marriage certificates, divorce decrees, high school or college diplomas, employer ID cards or property deeds/titles. Voter registration cards are not acceptable;
- Disabled individuals in residential care facilities may have identity attested to by the facility director or administrator, on behalf of the individual in the facility, when the individual does not have or cannot get any document listed above. This affidavit must be signed under penalty of perjury, but need not be notarized.
- Children under age 16 years of age may have their identity documented using other means:
  - Clinic, doctor or hospital record;
  - School records including report card, day care or nursery school record. Records must be verified with the issuing school;
  - If no other documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative may be used. An identity affidavit should not be used if a citizenship affidavit was used. Identity affidavits need not be notarized. Identity affidavits may be used for children under 18 years of age when a school ID card or driver's license is not available to the child until he/she is 18 years of age.

Evidence that Establishes U.S. Citizenship for Collectively Naturalized Individuals

Puerto Rico

- Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's or recipient's (A/R's) statement that he/she was residing in the U.S., a U.S. possession or Puerto Rico on 1/13/1941; or
- Evidence that the A/R was a Puerto Rican citizen and the A/R's statement that he/she was residing in Puerto Rico on 3/1/1917 and that he/she did not take an oath of allegiance to Spain.

U.S. Virgin Islands

- Evidence of birth in the U.S. Virgin Islands, and the A/R's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927; or
- The A/R's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927, and that he/she did not make a declaration to maintain Danish citizenship; or
- Evidence of birth in the U.S. Virgin Islands and the A/R's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932.

Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands [TTPI])

- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the A/R's statement that he/she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or
- Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the A/R's statement that he/she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or
- Evidence of continuous domicile in the NMI since before 1/1/1974 and the A/R's statement that he/she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time). If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

Immigrant Status

- The following are the most common United States Citizenship and Immigration Services (USCIS) Forms:
  - I-551 Permanent Resident Card;
  - I-94 Arrival/Departure Record;
  - I-766 Employment Authorization Card;
- United States Citizenship and Immigration Services (USCIS) Form I-797 Notice of Action; or
- Evidence of continuous United States residence prior to 1972.

NOTE: If you are applying only for Medical Assistance, you do not have to tell us about your citizenship or immigration status if you are:

- Pregnant; or
- An undocumented alien applying for Medical Assistance coverage because of an emergency medical condition. (See Medical Assistance section of Book 2, LOCAL DEPARTMENT OF SOCIAL SERVICES-4148B for more information on citizenship or immigration status.)

Documentation Guide
Citizenship and Immigrant Eligibility for Health Coverage in New York State

Listed below are citizenship and immigration documents that can establish one's status when applying for **public health coverage** in New York State. These documents can also be used for the purposes of applying for other federal and state benefit programs. The categories of immigrants who are eligible will vary with each benefit program.

Immigrant Eligibility for Medicaid and/or Family Health Plus

In New York State, U.S. Citizens, Nationals, Native Americans and individuals with satisfactory immigration status[1] (i.e., Qualified immigrants and PRUCOL) listed under the following categories may be eligible for Medicaid and/or Family Health Plus.

Immigrant Eligibility for Other Health Care Programs

New York State residents, regardless of their immigration status, may be eligible for Child Health Plus (CHPlus), Prenatal Care Assistance Program (PCAP), the treatment of an emergency medical condition, and sliding-fee scale at the public hospitals and clinics. For each program, the immigrant must meet other eligibility criteria, including income requirements.

Category 1: U.S. Citizens

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
United States Citizen: (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.) *Note: Listed are the most common documents used to prove U.S. citizenship. The list is not exhaustive and there are other documents that can establish U.S. citizenship.* **CITIZENSHIP REMINDERS:** A birth certificate can no longer be accepted as proof of both citizenship and identity. If the birth certificate is presented as proof of citizenship, the worker must obtain another form of identity document from the Identity documentation list, such as a driver's license. All documents must be originals or copies certified by the issuing agency. Workers are required to photocopy the original/certified copy and annotate the copy with their initials and the date of the review.	**Primary Documents** **(No other document required)** ►U.S. Passport; ►Certificate of Naturalization (N-550 or N-570); or ►Certificate of U.S. Citizenship (N-560 or N-561). **Secondary Documents** (When a primary document is unavailable, a secondary document may be used, but also requires ONE identity document from the identity documentation list below.) ►U.S. Birth Certificate showing birth in one of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 1/13/1941), Virgin Islands of the U.S. (on or after 1/17/1917), Northern Mariana Islands (after 11/4/1986 [NMI local time]), or Guam (on or after 4/10/1899); ►Certification of Report of Birth issued by the Department of State (DS-1350); ►Report of Birth Abroad of a U.S. Citizen (FS-240); ►Certification of birth issued by Department of State (Forms FS-545 or DS-1350); ►U.S. Citizen Identification Card (I-197 or I-179); ►Northern Mariana Identification Card (I-873); ►American Indian Card with classification code of "KIC" (I-872); ►Final adoption decree showing U.S. place of birth; ►Evidence of U.S. civil service employment before 6/1/1976; ►Military record of service showing U.S. place of birth (i.e., DD-214); or ►Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000. **Third Level Documents** (When a primary or secondary document is not available; also requires an identity document.) ►Extract of hospital record on hospital letterhead. The record must have been established at the time of birth and the extract must have been created at least 5 years before the Medicaid application date (or, for children younger than 16, near the time of birth) and must show a U.S. place of birth; ►Life, health or other insurance record, if it shows a U.S. place of birth and was created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth);	C	YES	**A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.** **Note: Pregnant women are excluded from this requirement.**

Category 1: U.S. Citizens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
U.S. Citizen (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)	**Third level Documentation** (continued) (When a primary or a secondary document is not available: also requires ONE identity document.) ►Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made; or ►Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents. **Fourth Level Documents** (Are the least reliable and should only be used in rarest of circumstances; also requires an identity document.) ►Federal or State census record showing U.S. citizenship or a U.S place of birth; or ►The following other documents are acceptable if they indicate a U.S. place of birth and were created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth): ▪ Medical (clinic, doctor, or hospital) record; ▪ Seneca Indian tribal census; ▪ Bureau of Indian Affairs tribal census records of the Navajo Indians; ▪ U.S. State Vital Statistics official notification of birth registration; ▪ Delayed U.S. public birth record that is recorded more than 5 years after the person's birth; ▪ Statement signed by the physician/midwife who was in attendance at the time of birth; or ▪ Bureau of Indian Affairs Roll of Alaska Natives; ►Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5 years before the application date) showing a U.S. place of birth; or ►Written affidavit (to be used only in rare instances). The affidavit must contain the following information under the following circumstances: • There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. • The two affidavits can be combined in a joint affidavit. • At least one of the individuals making the affidavit **cannot** be related to the applicant or recipient. • The person(s) making the affidavit **must** be able to provide proof of his or her own citizenship and identity for the affidavit to be accepted. • The affidavit **must** also be signed **under penalty of perjury** by the person making the affidavit, but need not be notarized. A separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why documentary evidence does not exist or cannot be readily obtained **must** also be obtained.	C	YES	**A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.** **Note: Pregnant women are excluded from this requirement.**

Category 1: U.S. Citizens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Collectively Naturalized Evidence that establishes U.S. Citizenship for Collectively Naturalized individuals.	Puerto Rico ►Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's or recipient's (A/R's) statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on 1/13/1941; or ►Evidence that the A/R was a Puerto Rican citizen and the A/R's statement that he or she was residing in Puerto Rico on 3/1/1917 and that he or she did not take an oath of allegiance to Spain. U.S. Virgin Islands ►Evidence of birth in the U.S. Virgin Islands, and the A/R's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927; or ►The A/R's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927, and that he or she did not make a declaration to maintain Danish citizenship; or ►Evidence of birth in the U.S. Virgin Islands and the A/R's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands [TTPI]) ►Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or ►Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time); or ►Evidence of continuous domicile in the NMI since before 1/1/1974 and the A/R's statement that he or she did not owe allegiance to a foreign State on 11/4/1986 (NMI local time). If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.	**C**	**YES**	**A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.** **Note: Pregnant women are excluded from this requirement**

Category 1: U.S. Citizens continued

Category	Identity Documents (One identity document **must** be used with secondary, third or fourth level citizenship documentation).	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
U.S. Citizen (Includes the 50 U.S. States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and American Samoa, Swain's Island and the Northern Mariana Islands for purposes of Medicaid eligibility.)	►A driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. Canadian driver's licenses may not be used; ►School identification card with a photograph of the individual; ►U.S. military card or draft record; ►Identification card issued by Federal, State, or local government with the same information included on the driver's license; ►Military dependent's identification card; ►Certificate of Degree of Indian Blood, or other U.S. Native American/Alaska native tribal document with photo or other identifying information; ►U.S. Coast Guard Merchant Mariner card; ►A cross-match with a Federal or State governmental, public assistance, law enforcement, or corrections agency's data system; ►If **none** of the above identity documents is available, a combination of three or more corroborating documents such as marriage certificates, divorce decrees, high school or college diplomas, employer ID cards or property deeds/titles. Voter registration cards are not acceptable; ►Disabled individuals in residential care facilities may have identity attested to by the facility director or administrator, on behalf of the individual in the facility, when the individual does not have or cannot get any document listed above. This affidavit must be signed under penalty of perjury but need not be notarized. ►Children under age 16 may have their identity documented using other means: ▪ Clinic, doctor or hospital record; ▪ School records including report card, day care or nursery school record. Records must be verified with the issuing school; ▪ Affidavit signed under penalty of perjury by a parent, guardian or caretaker relative stating the date and place of the child's birth, if no other documents are available. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under 18 when a school ID card or driver's license is not available to the child until he or she is 18 years of age.	C	**Not applicable to identity documents**	**Not applicable to identity documents**

Satisfactory Immigration Status[1]

Category 2: Qualified Aliens

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Native Americans born in Canada	►I-94 coded "S1-3"; ►I-551 Permanent Resident Card stamped "S1-3"; ►Temporary I-551 stamp coded S1-3 in a Canadian passport; or ►Tribal Record or document certifying at least 50% American Indian blood, as required by Section 289 of the INA and satisfactory evidence of birth in Canada such as the following: -Birth or Baptismal Certificate issued on a reservation; -Letter from Canadian Department of Indian Affairs; **or** -School Records.	**C**	**YES**	**For the purpose of Medicaid, Native Americans are classified as U.S. citizens.** ` **A SSN is an eligibility requirement for all citizens applying for Medicaid or FHP.** **Note: Pregnant women are excluded from this requirement**
Native Americans belonging to a Federally recognized Tribe born outside the U.S.	►Membership card or other tribal document demonstrating (i.e., tribal card) membership in a federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and satisfactory evidence of birth outside the U.S.	**C**	**YES**	
Refugees	►I-94 or foreign passport with annotation "Section 207" of the INA or "Refugee", RE1, RE2, RE3, or RE4; ►I-551 coded R8-6, RE6, RE7, RE8, or RE9; ►I-571 Refugee Travel Document; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(3); **or** ►I-766 Employment Authorization Document annotated "A3".	**R**	**YES**	**Immigrants with or without work authorization are required to apply for a Social Security Number.** **LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requires for federal or state benefits, except for having an SSN (08 OHIP INF-2)** **Note: Pregnant women are excluded from this requirement.**
Asylees	►I-94 or foreign passport annotated "granted Asylum under Section 208" of the INA", "Section 208" or "Asylee"; ►I-551 coded AS1, AS2, AS3, AS6, AS7, or AS8; ►I-571 Refugee Travel Document; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(5); ►I-766 Employment Authorization Document annotated "A5"; **or** ►Grant letter/order from the USCIS[2] Asylum Office or Immigration judge granting asylum.	**A**	**YES**	
Persons granted withholding of deportation or removal (Non-citizens whose deportation or removal has been withheld based on a finding that the person's life or freedom is threatened in the country of deportation based on race, religion, nationality, or membership in a particular social group or political opinion.)	►I-94 or foreign passport stamped "Section 243(h)" or "Section 241(b)(3)"; ►I-766 Employment Authorization Document annotated "A10"; ►Order issued by an immigration judge, the Board of Immigration appeals or a federal court showing the date that deportation was withheld under Section 243(h) of the INA, as in effect prior to April 1, 1997, or the date that removal was withheld under Section 241(b)(3) of the INA.	**J**	**YES**	

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Cuban/Haitian Entrants	►I-94 with annotation "Cuban-Haitian Entrant" section 212(d)(5) of the INA, CU6, CU7 or any other notation indicating "parole" under 212(d)(5) on or after 10/10/80; and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; ►I-551 coded CU6, CU7, CH6, CN-P, LB-2, LB-6, or LB-7; ►Temporary I-551 stamp coded "CU-6" or "CU-7 in a foreign passport; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(c)(8), and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; ►I-766 Employment Authorization Document annotated "C8", and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; ►Order to Show Cause (OSC), I-221S, or Notice to Appear (NTA), I-862, indicating pending exclusion, removal or deportation proceedings and satisfactory evidence that the parolee has been a citizen of Cuba or Haiti; **or** ►Any document indicating pending asylum application or filing of I-589 Application for Asylum, with satisfactory evidence on the document that the person has been a citizen of Cuba or Haiti.	**H**	**YES**	**Immigrants with or without work authorization are required to apply for a Social Security Number.** **LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN.** **(08 OHIP INF-2)** **Note: Pregnant women are excluded from this requirement.**
Amerasians	►I-94Arrival/Departure Record of Vietnamese passport or exit visa stamped "AM1, AM2, AM3, AM6, AM7, or AM8". ►I-551 Permanent Resident Card coded "AM1, AM2, AM3, AM6, AM7, or AM8"; ►Temporary I-551 stamp in Vietnamese passport "AM1, AM2, AM3, AM6, AM7, or AM8"; or ►I-571 Refugee Travel Document.	**R**	**YES**	
Victims of a Severe Form of Human Trafficking	►I-94 Arrival/Departure Record coded T1, T2, T3, T4, or T5 stating admission under Section 212(d)(5) of the INA if status is granted for at least one year; ►Certification letter (for adults) or eligibility letter (for children) from the Office of Refugee Resettlement. Must call 1-866-401-5510 for verification; **or** ►**I**-797 Notice of Action acknowledging receipt of I-914, Application for T non-immigrant status..	**D** Upstate **R** NYC	**YES**	
Veterans (Immediate family members: documentation of relationship to veteran)	►DD Form 214 showing "Honorable" discharge; **or** ►Original or notarized copy of the veteran's discharge papers.	**V**	**YES**	
Persons on active duty in the Armed Forces and their immediate family members.	►Military I.D. card - DD Form 2 (active); ►Original or notarized copy of current orders showing the person is on full-time duty in U.S. Armed forces; **(Immediate family members must show documentation of relationship to the person on active duty.)**	**M**	**YES**	

Category 2: Qualified Aliens continued

Please Note:

Qualified Aliens who are Eligible for State Medicaid until becoming Eligible for Federal Medicaid after a Five Year Waiting Period: Qualified aliens listed below, who entered the U.S. before August 22, 1996, are eligible for federal Medicaid, if otherwise eligible. However, qualified aliens in these four categories who entered the U.S. on or after August 22, 1996, are subject to the federal five year ban. This means that they are *not* eligible for federally funded Medicaid until they have resided in the U.S. for five years in a qualified alien status. Until becoming eligible for federally funded Medicaid, these qualified aliens are eligible for State funded Medicaid coverage of all medically necessary care and services, if they meet the program's other eligibility requirements. Districts must enter the appropriate State/federal charge codes to assure proper claiming of federal and State shares. For these individuals the date they physically entered the U.S. will determine whether or not Federal Financial Participation (FFP) is available. This date is called the "Date Entered Country" (DEC). During their first five years in the U.S the cost of their Medicaid coverage will be born solely by State and local shares (50% State/50% local). Once a qualified alien in this group has resided in the United States as a qualified alien for a period of five years, FFP will become available. This means the federal government will pay a share of their Medicaid costs.

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Lawful Permanent Residents (LPRs or "green card" holders)	►I-94 Arrival/Departure Record or foreign passport stamped I-551; ►I-551 Lawful Permanent Resident Card "green card" ►I-327 Reentry permit; **or** ►I-181 Memorandum of Creation of Record of Lawful Permanent Residence with approval stamp.	**K** (without 40 quarters) OR **S** (with 40 quarters)	**YES** After 5 yrs in a qualified status	**Immigrants with or without work authorization are required to apply for a Social Security Number.** **LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN (08 OHIP INF-2)** **Note: Pregnant women are excluded from this requirement.**
Parolees admitted into the U.S. for at least one year (Non-citizens who have been allowed to come into the U.S. for humanitarian or public interest reasons.)	►I-94 Arrival/Departure Record with annotation "Paroled Pursuant to Section 212(d)(5)" or "parole" or "PIP" or "public interest" with the date of entry and date of expiration indicating **at least one year**; ►I-688B Employment Authorization Card annotated 8 C.F. R. 274a.12(a)(4) or 274a.12(c)(11); **or** ►I-766 Employment Authorization Document annotated "A4" or "C11".	**G**	**YES** After 5 yrs in a qualified status	
Conditional Entrants ***(Status granted to refugees before 1980.)***	►I-94 Arrival/Departure Record stamped Section 203(a)(7), or otherwise indicating status as a conditional entrant; ►I-688B Employment Authorization Card annotated 8 C.F.R.274a.12(a)(3); **or** ►I-766 Employment Authorization Document annotated "A3".	**F**	**YES** After 5 yrs in a qualified status	

Category 2: Qualified Aliens continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Victims of Battery/Abuse **The term "battered qualified alien" includes the following immigrants described at 8 U.S.C. §1641(c):** ▪ **an alien who has been battered or abused in the U.S. by a spouse or parent, or by a member of the spouse's or parent's family residing in the same household as the alien; or** • **the parent of a battered or abused child; or** • **the child of a battered or abused parent.** **A substantial connection must also exist between the battery or abuse and the need for public benefits such as Medicaid. The alien must no longer be living with the batterer or abuser.**	**A variety of documents provide evidence that an alien meets this definition.** ►I-797 Notice of Action **indicating that the alien has an approved I-360 self petition (Do not refer to DVL);** ►I-797 Notice of Action **indicating that the alien has a pending I-360 self-petition that has established a prima facie case (Do not refer to DVL);** ►Order from the Executive Office for Immigration Review ("EOIR") **granting or finding a prima facie case for granting, suspension of deportation or cancellation of removal (Do not refer to DVL);** or ►I-797 Notice of Action **indicating that the alien has a pending I-360 self petition AND credible evidence of battery or abuse (Request alien's permission to refer to DVL); or** ►I-797 Notice of Action **indicating the alien is the beneficiary of a pending or approved I-130 petition** and **credible evidence of battery and/or abuse (Request alien permission to refer to DVL);** or ►I-94 **coded, K3, K4, V1 V2 or V3** and **credible evidence of battery or abuse (Request alien's permission to refer to DVL); or** **►Any other USCIS document indicating the alien has a K or V visa and a pending or approved I-130 petition with credible evidence of battery or abuse (Request alien's permission to refer to DVL); or** **►I-94 or Foreign passport annotated CR1, CR2, CR6, CR7 with credible evidence of battery or abuse (Request alien's permission to refer to DVL); or** **►I-688B Employment Authorization Card annotated 274a.12(a)(9)-spouse/children of USC or LPR (K or V visa), 274a.12(a)(15)-spouses and dependents of LPR (K or V visa), 274a.12(c)(10)-applicant for suspension of deportation with credible evidence of battery or abuse (Request alien's permission to refer to DVL); or** **►I-766 Employment Authorization Document annotated A9, A15 or C10 with credible evidence of battery or abuse (Request alien's permission to refer to DVL).**	**B**	**YES** After 5 yrs in a qualified status	**Immigrants with or without work authorization are required to apply for a Social Security Number.** **LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)** **Note: Pregnant women are excluded from this requirement.**

NOTE: Referral to a domestic violence liaison (DVL): Medicaid-only offices must refer alien applicants and recipients who must demonstrate that they are credible victims of domestic violence to be considered qualified for Medical assistance as "battered aliens" to the DVL for a credibility assessment. Those applicants and recipients who cannot document eligibility in any other category and cannot document that the United States Citizenship and Immigration Services (USCIS) or immigration court has determined the immigrant has in fact been subject to battery or extreme cruelty will need to see the district's DVL for a credibility determination. If districts are unable to verify that an acceptable immigration document has been filed with USCIS, districts can accept the alien's written attestation and then refer the alien to an immigration attorney or legal services for assistance. The DVL does not have the authority to determine eligibility for assistance.

Category 3: Persons who are Permanently Residing in the U.S. Under Color of Law (PRUCOL)*

*PRUCOL is not an immigration status. PRUCOL is not granted by the USCIS. PRUCOL is a public benefits eligibility category.

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
a. Persons paroled into the U.S. for less than a year. *(Non-citizens allowed to come into the U.S. without being granted admission.*	►I-94 Arrival/Departure Record with annotation "Paroled Pursuant to Section 212(d)(5)" of the INA or "parole" or "PIP"; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12(a)(4) or 274a.12(c)(11); **or** ►I-766 Employment Authorization Document annotated "A4" or "C11".	**T**	**NO**	**Immigrants with or without work authorization are required to apply for a Social Security Number.** **LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)** **Note: Pregnant women are excluded from this requirement.**
b. Persons under an Order of Supervision. (Non-citizens who have been found deportable; however certain factors exist which make it unlikely that they will be deported.)	►I-94 Arrival/Departure Record annotated "Order of Supervision"; ►I-220B Order of Supervision; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12 (c)(18); **or** ►I-766 Employment Authorization Document annotated "C18".	**O**	**NO**	
c. Persons granted indefinite stay of deportation (Non-citizens who have been found deportable, but deportation is deferred indefinitely due to humanitarian reasons.)	►I-94 Arrival/Departure Record coded 106 "granted Indefinite Stay of Deportation"; **or** ►Letter/order from the immigration agency, immigration judge or a federal court granting indefinite stay of deportation.	**O**	**NO**	
d. Persons granted indefinite voluntary departure (Status that was granted before April, 1997 to non-citizens who have been found deportable, but deportation is deferred indefinitely due to humanitarian reasons.)	►I-94 Arrival/Departure Record or letter/order from the immigration agency or immigration judge granting voluntary departure for an indefinite time period.	**O**	**NO**	
e. Persons on whose behalf an immediate relative petition has been approved and family members covered by the petition. (Non-citizens who are immediate relatives (spouse, father, mother, or unmarried child under 21) of a U.S. citizen/LPR who has filed an I-130 Relative Petition on their behalf.)	►I-94 Arrival/Departure Record or I-210 indicating departure on a specified date, however, the USCIS expects the non-citizen's visa will be available within this time; or ►I-797 indicating I-130 Relative Petition has been approved.	**O**	**NO**	
f. Persons who have filed applications for adjustment of status to lawful permanent resident under Section 245 of the INA that the USCIS has accepted as "properly filed". (Non-citizens who filed for legal permanent resident status.)	►I-94 Arrival/Departure Record or foreign passport with annotation "adjustment application" or "employment authorized during status as adjustment applicant"; ►I-688 Temporary Resident Card or I-688A Employment Authorization Card annotated "245A"; ►I-688B Employment Authorization Card annotated 8 C.F.R. 274a.12 (c)(22); or ►I-766 Employment Authorization Document annotated "C22".	**O**	**NO**	

Category 3: PRUCOL continued

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
g. Persons granted stays of deportation (Non-citizens who have been found deportable, but the USCIS may defer deportation for a specified period of time due to humanitarian reasons.)	►I-94 Arrival/Departure Record or letter/order from the immigration agency, immigration judge or court granting stay of deportation.	**O**	**NO**	**Immigrants with or without work authorization are required to apply for a Social Security Number.**
h. Persons granted voluntary departure under Section 242(b). *(This section of the INA has been repealed.)*	►I-797 Notice or form showing grant of extended voluntary departure; ►I-688B Employment Authorization Card annotated 274a.12(a)(11); or ►I-766 Employment Authorization Document annotated A11.	**O**	**NO**	
i. Persons granted deferred action status.	►I-797 or any document from USCIS granting deferred action status; ►I-688B Employment Authorization Card annotated 8 C.F.R 274a.12 (c)(14); or ►I-766 Employment Authorization Document annotated "C14".	**O**	**NO**	
j. Persons who entered and continuously resided in the U.S. before January 1, 1972. ***(Non-citizens are presumed by the USCIS to meet certain criteria for legal permanent residence.)***	►Any documentary proof establishing entry and continuous residence; or ►I-688B or I-766 coded 274a.12(c)(16) or C16; or ►I-797, letter/notice from the USCIS or court indicating registry application is pending.	**O**	**NO**	**LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)**
k. Persons granted suspension of deportation pursuant to Section 244 of the INA; the USCIS does not contemplate enforcing departure *(Non-citizens in this category have been found deportable, have met a period of continuous residence and have filed an application for the USCIS to suspend deportation, which has been* granted.**)**	►I-797, letter/notice from an immigration judge or court; **and** ►I-94 Arrival/Departure Record showing suspension of deportation granted. (After Lawful Permanent Residence is granted the person will have a "green Card" Form I-551).	**O**	**NO**	
l. Other persons living in the U.S. with the knowledge and permission or acquiescence of the USCIS and whose departure the USCIS does not contemplate enforcing: **Examples include, but are not limited to:** ►Applicants for adjustment of status to LPR[1], asylum[2], suspension of deportation or cancellation of removal[3] or requesting deferred action; or ►Persons granted Deferred Enforced Departure (DED)[4] due to conditions in their home country; or ►Permanent non-immigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States of Micronesia and the Marshall Islands[5]; ►Persons granted Temporary Protected Status[6]; or ►Applicants for Temporary Protected Status[7] (TPS); or ►Persons having a K, V, S or U Visa.[8]	►I-94 Arrival/Departure Record coded K1, K2, K3, K4, V1, V2, or V3, T, U, or S; ►I-688B Employment Authorization Card annotated 8 C.F.R.274a.12(c)(9)[1], 274a.12(c)(8)[2] 274a.12(c)(10)[3], 274a.12(a)(11)[4] 274a.12(a)(8)[5], 274a.12(a)(12)[6] or 274a.12(c)(19)[7], 274a.12(a)(9)[8], 274a.12(a)(13)[8], 274a.12(a)(15)[8], 274a.12(c)(21)[8],and 274a.12(c)(24)[8] ►I-766 Employment Authorization Document annotated C9[1], C8[2], C10[3], A11[4], A8[5], A12[6], C19[7], A9[8], A13[8], A15[8], C21[8] or C24[8]. ►I-797 indicating the USCIS has received an application or petition or request for change of status; or ►Postal Return Receipt addressed to the federal immigration agency* or a copy of a cancelled check to the federal immigration agency, **and** a copy of the application, petition or request submitted to the federal immigration agency. (* **USCIS**-United States Citizenship and Immigration Services; **ICE-**Immigration and Customs Enforcement; **EOIR-**Executive Office of Immigration Review.)	**O**	**NO**	**Note: Pregnant women are excluded from this requirement.**

Category 4: Non-Immigrants

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Temporary Non-immigrants include but are not limited to the following visa types:: **A -** Foreign government representatives on official business; **B-1 or B-2 -** Visitors for business or pleasure; **D -** Crewmember on shore leave; **E -** Treaty Traders and investors; **F -** Foreign students; **G -** Representatives of international organizations; **H -** Temporary workers (including agricultural workers); **I -** Members of the foreign press; **J -** Exchange visitors; **L -** Intra-company transferee; **O -** Persons with extraordinary ability or achievement; **P -** Artists, Entertainers and Athletes; **Q -** Cultural Exchange Visitors; and **R -** Religious workers.	►I-94 Arrival/Departure Record or foreign passport stamped with nonimmigrant code; ►I-185 Canadian Border Crossing Card*; ►I-586 Mexican Border Crossing Card*; ►I-444 Mexican Border Visitor's Permit; or ►I-95A Crewmen's Landing Permit. ►I-688B Employment Authorization Card ►I-766 Employment Authorization Document *B-1/B-2 Visa/Border Crossing Card (BCC) is now issued in place of these documents (Temporary non-immigrants are lawfully admitted to the U.S. for a temporary or specified period of time.)	**E** **Only eligible for the treatment of an Emergency medical condition**	**YES**	**NOT Required.** **However, may be assigned an SSN if USCIS/DHS has granted permission to work.**
Special Non-immigrants: Some categories of non-immigrant status allow the status holder to work and eventually adjust to lawful permanent residence. These categories allow the individual to apply for the adjustment to LPR status after he or she has had the nonimmigrant status for a period of time. As SPECIAL NON-IMMIGRANTS, (K), (S), (T)*, and (V) visa holders are PRUCOL and are eligible for Medicaid/FHPlus/CHPlus. *** Victims of Trafficking (T visas) receive benefits to the same extent as refugees (04 OMM/ADM-7).**	►I-94 Arrival/Departure Record coded K3, K4, V1, V2, or V3, T*, U, or S; ►I-797 indicating the USCIS has received, taken action on or approved an application or petition; ►Postal Return Receipt addressed to the USCIS or copy of cancelled check to the USCIS **and** a copy of the enclosed documents submitted to the USCIS, or ►Correspondence to or from the USCIS, showing that the person is living in the U.S. with the knowledge and permission or acquiescence of the USCIS, and the USCIS does not contemplate enforcing the person's departure from the U.S.	**O** **PRUCOL*** ***EXCEPT FOR VICTIMS OF TRAFFICKING**	**NO**	**LDSS must provide immigrants with a letter addressed to SSA for those immigrants without work authorization who met all the eligibility requirements for federal or state benefits, except for having an SSN. (08 OHIP INF-2)** **Note: Pregnant women are excluded from this requirement**

Category 5: Undocumented Aliens

Category	Documentation	WMS ACI Code	Federal Financial Participation (FFP)	Social Security Number (SSN) Requirement
Undocumented Aliens: (*Undocumented aliens do not have the permission of the USCIS to remain in the U.S. They may have entered the United States legally but have violated the terms of their status, e.g. over-stayed a visa, or they may have entered without documents.)*	Undocumented aliens are unable to provide documentation of immigration status, therefore, absent any documentation they are eligible only for the treatment of an emergency medical condition. Undocumented children may be eligible for CHPlus. Undocumented pregnant women continue to be eligible for PCAP.	**E** **Only eligible for the treatment of an emergency medical condition**	**YES**	**NOT Required**

Most Common U. S. Citizenship and Immigration Services (USCIS) Documents (Forms)

I-94	Arrival Departure Record/Card	I-688B	Employment Authorization Card
I-181	Memorandum of Creation of Record of Lawful Permanent Residence	I-766	Employment Authorization Document
I-210	Voluntary Departure	I-797	Notice of Action (I-797C current version)
I-220B	Order of Supervision	DD-Form 2	Military Identification Card
I-130	Petition for Alien Relative	DD-214	Report of Separation Military Discharge Document
I-140	Immigrant Petition for Alien Worker	N-560	Certificate of Citizenship
I-327	Permit to Reenter the United States	N-561	Certificate of Citizenship Replacement
I-360	Petition for Amerasian, Widow(er), or Special Immigrant (VAWA) Self-Petitioner	N-550	Certificate of Naturalization
I-551	Permanent Resident Card, Resident Alien Card or "green card"	N-570	Certificate of Naturalization Replacement
I-571	Refugee Travel Document	I-197	United States Citizenship Identification Card (no longer issued, but still acceptable)
I-688	Temporary Resident Card	I-179	United States Citizenship Identification Card (no longer issued, but still acceptable)
I-688A	Employment Authorization Card for Legalization Applicants		

[1]Satisfactory immigration status is an immigration status that makes the individual eligible for benefits under the applicable program, if they meet the other eligibility requirements of the program.

[2]The United States Citizenship and Immigration Services (USCIS) was formerly the Immigration and Naturalization Services (INS) and the Bureau of Citizenship and Immigration Services (BCIS).

PLEASE NOTE:

The relevant DATE for ELIGIBILITY is the **DATE OF STATUS (DOS).** This is the **DATE QUALIFIED STATUS WAS GRANTED.**

The **DATE ENTERED THE COUNTRY (DEC)** is **the day the individual actually arrived in the country**. The DEC is optional for "O" PRUCOL category immigrants, however if it can be obtained it may be data entered.

MEDICAID CATEGORIES

Supplemental Security Income (SSI)	• In receipt of SSI
SSI-Related	• Aged (65 or older), Blind, or Disabled
Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD)	• 16 to 64 years of age • Certified disabled by either the Social Security Administration or state Disability Review Team • Engaged in paid work including full-time and part-time for which any applicable taxes are paid (people working in sheltered workshops are considered employed for the MBI program)
Low Income Families (LIF)	• Families with children under age 21 • Children under 21 not living with caretaker relatives • Applying caretaker relatives • Pregnant women
Single Individuals and Childless Couples (S/CC)	• 21 to 64 years of age • Childless couples
Child Health Plus	• Covers children under the age of 19 whose family income does not exceed 160% of FPL • Subsidizes coverage for children under the age of 19 whose family income is between 161% and 400% of FPL
Emergency Coverage for Aliens	• Emergency services provided to undocumented immigrants or temporary non-immigrants
ADC Related Household	• Child must meet appropriate categorical requirements of age, relationship, living with a specified relative, and deprivation of parental support or care
Pregnancy	• Pregnant women
Families Living With Dependent Children Under 21	• A family with two birth and/or adoptive parents in which their child under 21 is not deprived of parental support or care

2014 ELIGIBILITY FOR MEDICAID

Medicaid Category	General Eligibility	Financial Eligibility
Supplemental Security Income (SSI) recipients	• In receipt of SSI	• Countable resources of no more than $2,000 • Income within limits for specific living situation (see 2014 SSI Benefit Levels, page 225)
SSI-Related	• 65 years of age or older, Blind, or Disabled • Not in receipt of SSI due to income and/or resources that exceed Medicaid levels	With a spenddown has: • Countable resources of no more than $14,550 • Income within limits for specific living situation (see 2014 SSI Benefit Levels, page 225)
Medicaid Buy-In for Working People with Disabilities (MBI-WPD)	• 16 to 64 years of age • Certified disabled by SSA or state Disability Review Team • Engaged in paid work (part-time or full-time) for which applicable taxes are paid (people working in sheltered workshops are considered employed for the MBI program)	• Income less than 250% of Federal Poverty Level • Countable resources of no more than $20,000

Local Departments of Social Services

Albany County DSS

162 Washington Avenue
Albany, New York 12210
Phone: 518-447-7300

Medicaid
518-447-7240

Medicaid-SSI
518-447-7023

Long-term/Chronic Care
5th Floor Chronic Care Unit
518-447-7016

Allegany County DSS

County Office Building
7 Court Street
Belmont, New York 14813-1077
585-268-7661

Mail applications to this address.

Broome County DSS

36-42 Main Street
Binghamton, New York 13905-3199
607-778-2604

Medicaid
607-778-2702
607-778-2504

Medicaid-SSI
607-778-2613

Cattaraugus County DSS

Cattaraugus County Building
200 Erie Street
Little Valley, New York 14755
716-938-6913

Send all mail to:
One Leo Moss Drive, Suite 6010
Olean, New York 14760
716-373-8065

Cayuga County DSS

County Office Building
160 Genesee Street
Auburn, New York 13021-3433
315-253-1011

Direct written correspondence to specific unit/title (e.g., MA Supervisor or MA Unit).

Chautauqua County DSS

335 Central Avenue
Dunkirk, New York 14048
716-363-3500

110 East 4th Street
Jamestown, New York 14701
716-661-8200

Mail applications to Central Avenue address.

Chemung County DSS

Human Resource Center
425-447 Pennsylvania Avenue
P.O. Box 588
Elmira, New York 14902
607-737-5302 or 607-737-5360
607-737-5304 (fax)

Send applications and recertifications to this address. Address recertifications to individual worker if listed on the notice.

Chenango County DSS

P.O. Box 590
County Office Building
5 Court Street
Norwich, New York 13815
607-337-1500
607-334-8768 (fax)

Call first.

Clinton County DSS

13 Durkee Street
Plattsburgh, New York 12901-2911
518-565-3300

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Columbia County DSS

Medicaid Unit
25 Railroad Avenue
P.O. Box 458
Hudson, New York 12534
518-828-9411
518-822-9089 (fax)

Cortland County DSS

60 Central Avenue
Cortland, New York 13045-5590
607-753-5248

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Delaware County DSS

111 Main Street
Delhi, New York 13326
607-746-2325 or 607-746-6310
No appointments 8:00 a.m. – 10:30 a.m. Monday through Friday.

Dutchess County DSS

Medicaid Unit
60 Market Street
Poughkeepsie, New York 12601-3299
845-486-3000
845-486-3301

Erie County DSS

158 Pearl Street
Buffalo, New York 14202
716-858-6582

Mail applications to this address.

Essex County DSS

100 Court Street
P.O. Box 217
Elizabethtown, New York 12932-0217
518-873-3441

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Franklin County DSS

355 W. Main Street
Malone, New York 12953
518-483-6770

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Fulton County DSS

County Office Building
P.O. Box 549
Johnstown, New York 12095
518-736-5600

Medicaid
518-736-5625

Medicaid-SSI
518-736-5770

Genesee County DSS

5130 East Main Street
Suite # 3
Batavia, New York 14020
585-344-2587

Mail applications to this address.

Greene County DSS

Medicaid Unit
411 Main Street
Catskill, New York 12414
518-719-3700
518-719-3695

Hamilton County DSS

P.O. Box 725
White Birch Lane
Indian Lake, New York 12842-0725
518-648-6131

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Herkimer County DSS

301 North Washington Street
Suite 2110
Herkimer, New York 13350
315-867-1291

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Jefferson County DSS

250 Arsenal Street
Watertown, New York 13601
315-782-9030

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Lewis County DSS

Outer Stowe Street
P.O. Box 193
Lowville, New York 13367
315-376-5400

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Livingston County DSS

1 Murray Hill Drive
Mt. Morris, New York 14510-1699
585-243-7300

Send applications and recertifications to this address. Address recertifications to individual worker if listed on the notice.

Madison County DSS

P.O. Box 637
North Court Street
Wampsville, New York 13163
315-366-2211

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Monroe County DHS

111 Westfall Road
Rochester, New York 14620
585-274-6000

Send Medicaid applications and recertifications to "Team 47" at this address.

Montgomery County DSS

County Office Building
P.O. Box 745
Fonda, New York 12068
518-853-4646

Medicaid
518-853-8316

Medicaid-SSI
518-853-8313

Nassau County DSS

60 Charles Lindbergh Boulevard, Suite 160
Uniondale, New York 11553-3656
516 -227-8000/8280

New York City HRA – Bronx

Bronx Lebanon Hospital Medicaid Office
1316 Fulton Avenue (1st Floor)
718-860-4634/4635

Lincoln Hospital Medical Office
234 East 149th Street
Basement – Room B-75
718-585-7872/7920

Morrisania Medicaid Office
1225 Gerard Avenue, Basement
718-960-2799

North Central Bronx Hospital Medicaid Office
3424 Kossuth Avenue
1st Floor – Room 1A 05
718-920-1070

Agencies must go to the office nearest to their main address.
Offices are open 9:00 a.m. – 5:00 p.m. Monday through Friday.

New York City HRA – Brooklyn

NYC HRA
Medical Insurance and Community Services Administration
785 Atlantic Avenue
Brooklyn, NY 11238
Client Representative Unit: 929-221-2059/2052
Nursing Home Eligibility Division (ICFs): 718-557-1368, or NH Reception Desk: 929-221-2265/3526
Eligibility Information Services: 929-221-0865

Boerum Hill Medical Office
35 4th Avenue
718-623-7427/7428

Coney Island Medicaid Office
30-50 West 21st Street
718-333-3000

East New York Medicaid Office
2094 Pitkin Avenue, Basement
718-922-8292/8293

Kings County Hospital Medicaid Office
441 Clarkson Avenue

"T" Building Nurses' Residence, 1st Floor
718-221-2300/2301

Offices are open 9:00 a.m. – 5:00 p.m. Monday through Friday.
Coney Island office is also open on Saturdays from 9:00 a.m. until 12:00 noon.

New York City HRA – Manhattan

Bellevue Hospital Medicaid Office
462 First Avenue "G" Link
Ground Floor
212-679-7424

Chinatown Medicaid Office
115 Chrystie Street
5th Floor
212-334-6114

Manhattanville Medicaid Office
520-530 West 135th Street
1st Floor
212-939-0207/0208

Metropolitan Hospital Medicaid Office
1901 First Avenue
1st Floor, Rm. 1D-27
212-423-7006

NY Presbyterian Hospital Medicaid Office
622 West 168th Street
1st Floor, PH 040
212-342-5102/5103

Agencies must go to the office nearest to their main address.
Offices are open 9:00 a.m. – 5:00 p.m. Monday through Friday.

New York City HRA – Queens

Queens Medicaid Office
45-12 32nd Place – 1st Floor (aka 32-02 Queens Blvd)
Long Island City
718-752-4540
Offices are open 9:00 a.m. – 5:00 p.m. Monday through Friday.

New York City HRA – Staten Island

Staten Island Medicaid Office
215 Bay Street
718-420-4660/4732
Offices are open 9:00 a.m. – 5:00 p.m. Monday through Friday.

Niagara County DSS

20 East Avenue
P.O. Box 506
Lockport, New York 14095-0506
716-439-7600

301 10th Street
P.O. Box 865
Niagara Falls, New York 14302

Mail applications to Lockport address for the following zip codes:
14094 – Lockport
14131 – Ransomville
14132 – Sanborn

For all other Niagara County zip codes, mail applications to Niagara Falls address.

Oneida County DSS

800 Park Avenue
Utica, New York 13501-2981
315-798-5733

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Onondaga County DSS

Onondaga County Civic Center
421 Montgomery Street, 5th Floor
Syracuse, New York 13202-2923
315-435-2985

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Ontario County DSS

3010 County Complex Drive
Canandaigua, New York 14424-1296
585-396-4060 or 585-396-4061
1-877-814-6907 (from outside the county)
585-396-4597 (fax)

Send applications and recertifications to this address. Address recertifications to individual worker if listed on the notice.

Orange County DSS

Box Z
11 Quarry Road
Goshen, New York 10924
845-291-4000
845-291-4064 (fax)
www.orangecountygov.com

Orleans County DSS

14016 Route 31 West
Albion, New York 14411-9365
585-589-7000

Mail applications to this address.

Oswego County DSS

100 Spring Street
P.O. Box 1320
Mexico, New York 13114
315-963-5000

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Otsego County DSS

Mailing address:
County Office Building
197 Main Street
Cooperstown, New York 13326
607-547-1700
607-547-1721 (fax)

Location:
140 Meadows
Cooperstown, New York 13326

Putnam County DSS

Medicaid Unit
110 Old Route 6, Bldg. 2
Carmel, New York 10512
845-225-7040
845-808-1500
845-225-0947 (fax)

Rensselaer County DSS

547 River Street
Troy, New York 12180
518-266-7991 (Medicaid)
518-266-7800 (SNAP)

Rockland County DSS

The Dr. Robert L. Yeager Health Center
P.O. Box 307
Building L – Sanatorium Road
Pomona, New York 10970-0307
845-364-3040

Applications for 65/over and HCBS Waiver enrolled accepted

8:00 a.m. to 10:30 a.m. Tuesday, Wednesday and Thursday.

Saratoga County DSS

152 West High Street
Ballston Spa, New York 12020

Medicaid
518-884-4148/4237

Medicaid-SSI
518-884-4277

Schenectady County DSS

797 Broadway
Schenectady, New York 12305

Medicaid
518-388-4445/4745/4306/4755

HCBS Waiver
518-388-4255

Schoharie County DSS

County Office Building
P.O. Box 687
284 Main Street
Schoharie, New York 12157
518-295-8334

Schuyler County DSS

Human Services Complex
323 Owego Street, Unit 3
Montour Falls, New York 14865
607-535-8303 or 607-535-4965

Send applications and recertifications to this address. Address recertifications to individual worker if listed on the notice.

Seneca County DSS

1 DiPronio Drive, Box 690
Waterloo, New York 13165
315-539-1800
Fax: 315-539-9479

Send applications and recertifications to this address. Address recertifications to individual worker if listed on the notice.

St. Lawrence County DSS

Harold B. Smith County Office Building
6 Judson Street
Canton, New York 13617-1197
315-379-2111

Direct any written correspondence to a specific unit/title (e.g., MA Supervisor or MA Unit).

Steuben County DSS

3 East Pulteney Square
Bath, New York 14810
607-776-7611

Send applications and recertifications to this address. Address recertifications to individual worker if listed on the notice.

Suffolk County DSS

Chronic Care & MA-SSI Cases
Mailing Address:
P.O. Box 18100
Hauppauge, New York 11788-8900

Location:
3085 Veterans Memorial Highway
Ronkonkoma, New York 11779
Chronic Care: 631-854-5866
Medicaid-SSI: 631-854-5883

Medicaid West: Non-SSI Community Cases
Mailing Address:
Suffolk County DSS
P.O. Box 18100
Hauppauge, New York 11788-8900

Location:
Smithtown DSS
200 Wireless Blvd.
Hauppauge, New York 11788
631-853-8730

Medicaid East: Non-SSI Community Cases
Riverhead Center
893 East Main Street
Riverhead, New York 11901
631-852-3710

Sullivan County DSS
P.O. Box 231
16 Community Lane
Liberty, New York 12754
845-292-0100

Tioga County DSS
P.O. Box 240
Owego, New York 13827
607-687-8300
607-687-8093 (fax)

Tompkins County DSS
Human Service Building
320 West State Street
Ithaca, New York 14850
607-274-5327
607-274-5247 (fax)

Ulster County DSS
Medicaid Unit
1001 Development Court
Kingston, New York 12401-1959
Main: 845-334-5000
Medicaid: 845-334-5175
845-334-5420 (fax)

Warren County DSS
Municipal Center Annex
1340 State Route 9
Lake George, New York 12845
518-761-6300

Washington County DSS

Washington County Municipal Center
383 Broadway
Fort Edward, New York 12828
518-746-2300
518-746-2312 (fax)

Wayne County DSS

77 Water Street
P.O. Box 10
Lyons, New York 14489-0010
315-946-4881

Send applications and recertifications to this address. Address recertifications to individual worker if listed on the notice.

Westchester County DSS

Office of Medical Assistance and Medical Services

112 East Post Road
White Plains, New York 10601
914-995-3333

Wyoming County DSS

466 N. Main Street
P.O. Box 231
Warsaw, NY 14569-1080
585-786-8900

585-786-8927 (fax)

Send applications and recertifications to this address.
Address recertifications to individual worker if listed on the notice.

Yates County DSS

County Office Building
417 Liberty Street
Suite 2122
Penn Yan, New York 14527-1118
315-536-5183

Send applications and recertifications to this address. Address recertifications to individual worker if listed on the notice.

Explanation of the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD)

The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) offers Medicaid coverage for working people with disabilities who have net incomes at or below 250% of the Federal Poverty Level (FPL) and non-exempt resources at or below the Medicaid resource limit. The program is designed to help people with disabilities, who work, retain their health care coverage. If you have applied for Medicaid, the local Department of Social Services worker will tell you if you meet the eligibility requirements under the MBI-WPD program. Depending on your income, you may be asked to pay a monthly premium.

To qualify for the MBI-WPD program, you must:

- Be certified disabled by either the Social Security Administration (SSA) or State or Local District Disability Review Team; **and**
- Live in New York State; **and**
- Be at least 16 but less than 65 years of age; **and**
- Be engaged in work activity for which you receive financial compensation; **and**
- Meet the income and resource limits (see below); **and**
- Pay a premium, if required.

2009 MBI-WPD Program Income and Resource Levels*

The chart below shows how much net income you can receive in one month and the amount of resources you can retain and still qualify for Medicaid under the MBI-WPD program. The income and resource limits depend on whether you are single (1) or married (2), and if married, whether your spouse has a disability or sufficient income to be included in your budget.

Household Size	150% FPL	250% FPL	Resources **
1	$1,354	$2,257	$13,800
2	$1,822	$3,036	$20,100

*Income and resource levels are subject to yearly adjustments.
**If married, your resource limit is always for a household of (2).

Income may be a combination of earned and unearned income. Unearned income includes Social Security payments and retirement benefits. Earned income includes wages, salaries and any financial compensation for work. Some examples of resources may include checking or savings accounts, stocks and bonds, and cash value of life insurance policies. Not all your income and resources are counted to determine if you are eligible for the MBI-WPD program. Some examples of the deductions that may be taken from your gross monthly income include a $20 deduction and the first $65 of any earned income plus one-half of the remainder. Consult your local social services worker for other deductions that may apply. Certain burial trusts/funds may be disregarded from your resources.

Premium Payments

Under the MBI-WPD program, if your net income is less than 150% of the Federal Poverty Level (FPL), you will receive Medicaid coverage without paying a premium. If your net income is at least 150% but at or below 250% of the FPL, you will have to pay a monthly premium for Medicaid coverage.

Note: A premium payment will not be required at this time. Currently there is a moratorium on premium collection. When the premium requirement becomes effective you will be notified by mail.

The Medical Improvement Group: Participants in the MBI-WPD Basic group who are determined at the time of a Continuing Disability Review (CDR) to be no longer disabled but continue to have a severe medically determinable impairment may be eligible for continued coverage under the MBI-WPD Medical Improvement group. To qualify for this group, you must:

- Be determined eligible for the Medical Improvement group by the State Disability Review Team; **and**
- Meet ***all*** age, residency, income and resource requirements for the MBI-WPD program*; **and***
- Work ***at least 40 hours per MONTH*** in a work activity for which financial compensation is received; **and**
- Earn ***no less than the federal minimum wage; and***
- Pay a premium if required.

If you become a member of the Medical Improvement group you will be required to submit proof of work and wages to the local Department of Social Services every six months.

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)
BASIC GROUP GRACE PERIOD REQUEST FORM

Please complete, sign and date this form and return it with the required documentation (see below) to: _____
_____ by _____ .

NAME: _____

ADDRESS: _____

_____ COUNTY: _____

PHONE NUMBER: _____ CLIENT ID NUMBER (CIN): _____

I AM REQUESTING A GRACE PERIOD FOR CONTINUED PARTICIPATION IN THE MBI-WPD PROGRAM FOR THE FOLLOWING REASON: (Choose Medical Condition or Job Loss and check the appropriate boxes.)

☐ CHANGE IN MEDICAL CONDITION:

☐ Documentation Attached (Physician's statement needed)

☐ JOB LOSS

☐ Documentation Attached (layoff notice, statement from Department of Labor, VESID, etc. needed)

☐ This is a temporary layoff
My anticipated return date is _____

☐ I am actively seeking new employment

Please Explain: _____

_____

_____

Last Day Worked: _____

I certify, under penalty of perjury, that the information I have provided on this request form is true and complete to the best of my knowledge.

_____	_____	_____
Print Full Name	Signature of Applicant	Date

To be completed by Revenue Support Field Operations

LDSS Contact: _____ Phone #: _____

☐ REQUEST APPROVED Date: _____ Grace Period: _____ to _____

☐ REQUEST DENIED Date: _____

Reason for Denial: _____

If your request for a grace period is denied, no change is being made to your Medicaid coverage with this letter. You will receive a separate notice in the mail regarding your Medicaid coverage. The notice will include information on how to request an agency conference and/or a fair hearing.

_____	_____
Signature of LDSS Contact	Date

MBI-WPD GRACE PERIOD INFORMATION

What Are Grace Periods?

A grace period is a time period during which an MBI-WPD program participant is not working but remains eligible for the program. Two types of grace periods may be granted:

- Medical Reasons: a grace period of up to six months will be allowed, if the MBI-WPD participant is unable to continue working for medical reasons. Medical documentation will be required. When an MBI-WPD participant requests this type of grace period, medical documentation must be sent to the local Department of Social Services office.

- Grace Period for Job Loss: a grace period of up to six months will be allowed if through no fault of the participant, job loss is suffered, i.e., due to layoff, etc. Documentation is required. There is an expectation that the participant will return to employment (for example, if it is a temporary layoff) or that the participant is actively seeking new employment.

  Note: MBI-WPD participants reporting job loss due to non-medical reasons can contact the LDSS for a referral to One-Stop Centers, Vocational and Educational Services for Individuals with Disabilities (VESID) and Work Incentives, Planning and Assistance (WIPA) services as applicable, so that assistance with employment may be sought prior to loss of eligibility in the program.

How Do I Go About Getting a Grace Period?

A MBI-WPD participant must complete the grace period request on the opposite side of this form. The completed form, along with the required documentation must be submitted to your local Department of Social Services (LDSS) office.

How Often Can I Have a Grace Period?

Participants may be granted multiple grace periods during a 12-month period. However, in no event may the sum of the grace periods exceed six months in the 12-month period.

What Kind of Documentation Do I Need?

When applying for a Change in Medical Condition Grace Period, a physician's statement is required which contains the current health problem, treatment and the anticipated amount of time you will be out of work.

When applying for a Job Loss Grace Period, documentation is also required. Acceptable forms of documentation include layoff notice, statement from Department of Labor, VESID, etc.

How Will I Know if My Grace Period is Approved?

Your LDSS office will send you a letter informing you of your approval and the period of time authorized.

What Happens When I Return to Work?

You should immediately notify your LDSS office of your return to work. Unless you inform the LDSS office of your return to work, your grace period continues throughout the approved period. This is important because the sum of the grace periods cannot exceed six months in a 12-month period.

Will My Grace Period Affect My Premium Payments?

Premium payments are required for any recipient with net income (earned and unearned) that is at least 150% of the Federal Poverty Level (FPL) but at or below 250%FPL. You must notify your LDSS office immediately of any change in income. The LDSS office will use this information to determine if a premium is still required.

Note: A premium payment will not be required at this time. Currently there is a moratorium on premium collection. When the premium requirement becomes effective you will be notified by mail.

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. We will need to see original or certified copies of documents for identity and U.S. Citizenship. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring identity and U.S. citizenship documents. Many local departments of social services and Child Health Plus health plans do not accept original documents by mail, so please check with them if you wish to mail these documents. Copies of other documents can be mailed with your application.

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

Effective 7/1/10, citizen children who provide a social security number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.
You can provide ONE of the following documents to prove both U.S. Citizenship, Identity and your Date of Birth:

- U.S. passport book/card **OR**
- Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- Certificate of U.S Citizenship (DHS Forms N-560 or N-561) **OR**
- NYS Enhanced Driver's License (EDL).

When one of the above documents is not available, ONE document from EACH of the lists below 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

- 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)
- Native American Tribal Document*
- 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

Identity

- 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 Native American/Alaska native tribal document with photo
- Verified School, Nursery or Daycare records (for children under 16) (may also show date of birth)
- Clinic, Doctor or Hospital records (for children under 16)*

If you do not use one of the documents that show date of birth, you must also submit one of the following:

- Marriage certificate
- NYS Benefit Identification Card

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 both Immigration Status, Identity and your Date of Birth:
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
- Evidence of Continuous U.S. Residence prior to January 1, 1972

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 LIKE 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
- Current signed and dated income tax return and all Schedules
- 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.state.ny.us)
- 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

Worker's Compensation

- Award letter
- Check stub

Child Support/Alimony

- Letter from person providing support
- Letter from court
- Child support/alimony check stub
- Copy of NY Epicard with printout
- Copy of child support account information from **www.newyorkchildsupport.com**
- Copy of bank statement showing direct deposit

Veteran's 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).

Support from Other Family Members

- Signed statement or letter from family member

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you pay to have care for your children or parents 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

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)

Pregnant women only: proof of pregnancy, provide one of the following:

- Presumptive Eligibility Screening Worksheet for pregnant women completed by a qualified provider that tells us the expected date of delivery
- Statement from medical professional (such as a doctor or nurse practitioner) with the expected date of delivery
- WIC Medical Referral Form that tells us the expected date of delivery

If you have medical bills in the last three months, provide all the following:

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
- Medical bills for last three months, whether or not you paid them

ACCESS NY HEALTH CARE Medicaid / Family Health Plus / Child Health Plus

PLEASE READ the entire application and INSTRUCTIONS before you fill it out. 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 #	Another Phone #	What Language Do You
☐ Home ☐ Cell ☐ Work ☐ Other	☐ Home ☐ Cell ☐ Work ☐ Other	Speak? _____ Read? _____

HOME ADDRESS SEND PROOF
of the persons applying for health insurance
☐ 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:

Check all that apply
☐ Apply for /and or renew Medicaid for me
☐ Discuss my Medicaid application or case, if needed
☐ Get notices and correspondence

Name		State
Street	Apt.#	Zip Code
City		Phone # ☐ Home ☐ Cell ☐ Work ☐ Other

Section B Household 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, Family Health Plus or Child Health Plus **and list the ID Number from their Benefit Card or health plan ID card.** You **must** provide information for household members including: parents, step-parents, and spouses. You may provide information for other household members (for example, a dependent child under the age of 21).
Listing other household members may allow us to give you a higher eligibility level. Pregnant women and children under 19 may be eligible for health insurance regardless of immigration status.

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	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. Not needed for pregnant women SEND PROOF	*Race/ Ethnic Group
01	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No	SELF	☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the Above	
02	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the Above	

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

SEND PROOF **Refer to the Documents Needed When You Apply for Health Insurance in the instructions on pages 1-3, Documentation Checklist for Health Insurance, for a list of documents that prove Identity, Citizenship or Immigration Status.**

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

NYS DOH (Continued on page 2)

Section B Household Information (Continued from previous page)

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	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. Not needed for pregnant women SEND PROOF	*Race/ Ethnic Group
03	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ___/___/___ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the Above	
04	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ___/___/___ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the Above	
05	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ___/___/___ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the Above	
06	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ___/___/___ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the Above	
07	Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / ☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No What is the Due Date? / /	☐ Yes ☐ No		☐ Child Health Plus ☐ Medicaid ☐ Family Health Plus ID Number from Benefit Card/Plan Card, if known:		☐ U.S. Citizen ☐ Immigrant/non-citizen Enter the date you received your immigration status ___/___/___ Month Day Year ☐ Non-immigrant (Visa holder) ☐ None of the Above	

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

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

SEND PROOF **Refer to the Documents Needed When You Apply for Health Insurance in the instructions on pages 1-3, Documentation Checklist for Health Insurance, for a list of documents that prove Identity, Citizenship or Immigration Status.**

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

Section C Household 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: ☐ Check here if no earnings from work: ☐

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. Check here if no unearned income: ☐

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

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

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. Check here if none: ☐

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

1. Do you or any applying adult in Section B have no income? ☐ No ☐ Yes Who? _____

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

3. 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:

4. 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 Student's Name:

5. Do you have to pay for childcare (or for 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)*

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

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.** SEND PROOF
Complete the rest of this application and 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

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

3. Is the parent/step parent of any child applying a public employee who can get family coverage through a state health benefits plan? (see instructions) ☐ No ☐ Yes
If yes, does the public agency where that person works pay all or part of the cost of the health plan? ☐ No ☐ Yes

4. In the past 6 months, has anyone lost or cancelled any type of health insurance that was provided through an employer? ☐ No ☐ Yes (If no, skip to question 5) If yes, what date did you lose coverage? _____/_____/_____
Month Day Year

Your answer to this question will help us understand why people change their health insurance.

Why do the person(s) no longer have the health insurance? (Check only one)

☐ 1. The person who had the insurance no longer works for the employer that provided the insurance.
☐ 2. The employer stopped offering health insurance.
☐ 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent.
☐ 4. The cost of health insurance went up and it was no longer affordable.
☐ 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have.
☐ 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have.

5. Does your current job offer health insurance? **We may be able to help pay for it.** ☐ No ☐ Yes If yes, a "Request for Information-Employer sponsored Health Insurance" form will be sent to you.

Section E Housing Expenses

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

2. If you pay for water separately how much do you pay? $_____ SEND PROOF How often do you pay? ☐ every month ☐ 2 times a year ☐ quarterly (4 times a year) ☐ once a year

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

Section F Blind, Disabled, Chronically Ill or Nursing Home Care

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

If no one applying 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 (3) months before this month? Medicaid may be able to pay these bills or reimburse you.

☐ No ☐ Yes If yes: Name: _____ In which month(s) of the previous 3 months do you have medical bills? _____

SEND PROOF **of income for any month in the 3-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 (3) months? ☐ No ☐ Yes

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

If yes, who? _____ Which state? _____ Which county? _____

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

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

If yes, who? _____

Section H Parent or Spouse Not Living in the Household or Deceased

Families who are applying for their children and pregnant women 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? ☐ No ☐ Yes

If yes, name of applicant with deceased parent or spouse : _____ (If spouse or parent is deceased go to question 3.)

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

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

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

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

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

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

Section I Health Plan Selection

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

IMPORTANT: People with Family Health Plus and Child Health Plus **must** choose a health plan to get their health services. 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. **For Medicaid and Family Health Plus:** 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. For information about Child Health Plus plans, call 1-800-698-4543. 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 it provides Medicaid. If you live in a county that does not require people on Medicaid to join a health plan, you can tell us you do not want to be in a health plan by calling or writing to your Local Department of Social Services or by checking this box. ☐

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

Section J Signature

I agree to have the information on this application and on the annual renewal shared only among, Medicaid, Family Health Plus, Child Health Plus, the health plans indicated in Section I, the local social services district, and the facilitated enrollment 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, Family Health Plus, Child Health Plus, or to evaluate the success of these programs. Each applying adult must sign this application in the space below. By signing this application, I understand that each person applying for Medicaid, Family Health Plus, Child Health Plus, will be enrolled in the appropriate program, if eligible. **I have also 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* _____

TERMS, RIGHTS AND RESPONSIBILITIES

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

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid or Family Health Plus, I will tell the social services district. The social services district 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.
- By applying for Child Health Plus, I agree to pay the applicable premium contribution not paid by New York State.
- I understand that Medicaid, Family Health Plus, and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid or Family Health Plus, 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 these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that if my child is on Medicaid or Family Health Plus, he or she 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

Child Health Plus: SSNs are not required to enroll in Child Health Plus. If available, I will include it for children applying for Child Health Plus.

Medicaid, or Family Health Plus: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. 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 used in many ways, both within 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 applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. 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. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

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, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid enrolled providers.

FAMILY HEALTH PLUS AND MEDICAID MANAGED CARE

I understand that in order to receive Family Health Plus benefits, I must join a managed care health plan. I also know that in some counties, joining a health plan may be required to receive Medicaid. I have read how to find out whether my county requires Medicaid enrollees to join a health plan, and how to find out what health plans are available to me in Family Health Plus and in Medicaid managed care. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I/we also understand that if I/we are found eligible for Medicaid instead of Family Health Plus and I/we are in a county that requires Medicaid enrollees to be in a managed care health plan, I/we will be enrolled in the health plan I/we chose unless that health plan does not participate in Medicaid managed care. If I/we are in a county that does not require enrollees to be in a Medicaid managed care health plan, I/we will still be enrolled in the health plan I/we chose unless I/we notify my local social services department in writing, or I/we check the box in Section I, that I/we do not want to be in that plan.

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 both Family Health Plus and Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three (3) 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. I understand that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid managed care, 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 (SDOH) 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 SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus, and Family Health Plus 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 Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

- **Reimbursement of Medical Expenses**
  I understand that if I am determined eligible for Family Health Plus my enrollment will be effective no later than 90 days from the date of submission of a completed application. In the event of an error or delay in my enrollment, Medicaid may be able to reimburse me for reasonable medical expenses I pay as a result of the error or delay. Medicaid may pay my provider for any unpaid expenses only if that provider is a Medicaid enrolled provider.

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) ☐ Community-Based Facilitated Enrollment Agency ☐ Health Plan ☐ Social Services District ☐ Provider Agency ☐ Qualified Entities Employer Name: _____

To be completed by Facilitated Enrollers

Facilitated Enroller:		Lead Agency /Plan Name:		Lead Org/Plan. ID:
Language Used for Application Assistance:	Application Start Date:	Application Sequence Number:	Application Completion Date:	Enter Code of Applying Child: Medicaid _____ CHPlus _____

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 No:
Effective Date:	MA Disposition Reason Code: ☐ Denial Code ☐ Withdrawal	Proxy: ☐ Yes ☐ No	Registry No:	Ver:

To be used by Child Health Plus Plans

CHPlus Disposition: ☐ Approved ☐ Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):

Access NY Supplement A

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 F 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 G through I.

A. This Supplement is being completed for:

Legal Last Name	Legal First Name	MI	Social Security Number	Marital Status

Note: The remaining questions are for the person(s) named above.

B. Blind, Disabled or Chronically ill

1. Are you 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.)

2. Are you Certified Blind by the Commission for the Blind and Visually Handicapped? ☐ Yes ☐ No
   (If yes, send proof.)

3. If you are disabled and working, are you interested in applying for the MBI-WPD program? ☐ Yes ☐ No
   The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) 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.

C. Are you living in an adult home or assisted living facility? ☐ Yes ☐ No

D. Resources/Assets (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. 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. You must submit documentation of the current amount of your resources.* These services include:

- 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 waivers and other services are Traumatic Brain Injury Program and Long Term Home Health Care Program.

☐ You are institutionalized and applying for coverage of nursing home care. You must submit documentation of your resources back to February 1, 2006, or the past 60 months, whichever is less.

* 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.

List all resources owned by you and/or your spouse/parent(s), including custodial accounts. **If applying for coverage of nursing home care,** also list any accounts closed since February 1, 2006, or in the past 60 months, whichever period is shorter; include 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):

Bank Name and Account Number	Name of Owner(s)	Current Dollar Amount	Closed Account Balance/ Date Closed
		$	$
		$	$
		$	$
		$	$
		$	$

2. Retirement Accounts (Deferred Compensation, IRA and/or Keogh):

Account Number	Name of Owner(s)	Type/Institution	Current Dollar Amount	Pay Out
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

3. Life Insurance Policies:				
Insurance Company	Policy Number	Name of Owner(s)	Cash Value	Face Value
			$	$
			$	$
			$	$
			$	$
			$	$

4. Annuities, Stocks, Bonds, Mutual Funds:			
Name of Owner(s)	Company	Date Purchased	Value
			$
			$
			$
			$
			$
			$
			$

5. Trust Accounts: If you and/or your spouse created or are the beneficiary of a trust, submit a copy of the trust, including the schedule of trust assets.

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

6. Burial Assets/Burial Contracts: (Include copies)

Do you and/or your spouse have a pre-paid funeral agreement for you or anyone else in your family? ☐ Yes ☐ No

Do you and/or your spouse have a burial space or plot for you or anyone else in your family? ☐ Yes ☐ No

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
		$
		$
		$

Do you have life insurance to be used as your burial fund? ☐ Yes ☐ No

If **yes**, what is your policy number(s)? _____

If **yes**, is the full cash value to be used for your burial expenses? ☐ Yes ☐ No

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

If **yes**, what is the policy number(s)? _____

If **yes**, is the full cash value to be used for burial expenses? ☐ Yes ☐ No

7. Vehicle(s): List all cars, trucks and vans. List all recreational vehicles, including campers, snowmobiles, boats and motorcycles.

Name of Owner(s)	Year/Make/Model	Fair-Market Value	Amount Owed	In Use?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

8. 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.

9. List Any Other Resources:

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

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,** please answer the following questions.

Name and Address of Owner(s)	Address of Property	Type of Ownership (Check one)	Equity value
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$
		☐ Individual ☐ Joint tenancy ☐ Life estate	$

F. Homestead

1. Do you and/or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No
2. If you are in a medical facility and own your home, do you intend to return to your home? ☐ Yes ☐ No
3. If **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.

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

G. Applicant Living in a Long-Term Care Facility/Nursing Home

Name of Facility	Date Admitted / /	Telephone Number ( )	
Street Address	City	State	Zip
Applicant's Previous Address	City	State	Zip

H. Asset Transfers

1. Transfers

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

c. 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? _____

d. 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

e. Did you, your spouse, or someone on your behalf purchase a mortgage, loan, or promissory note? ☐ Yes ☐ No
If **yes,** when? _____

f. Did you, your spouse, or someone on your behalf purchase or change an annuity? ☐ Yes ☐ No
If **yes,** when? _____

2. 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 any 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
			$
			$
			$
			$

3. 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? **If yes, send copy of agreement.** ☐ Yes ☐ No

I. Tax Returns

Did you and/or your spouse file U.S. income tax returns in the last four years? ☐ Yes ☐ No
If yes, send copies of these returns.

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.

Federal and State laws provide that any transfer of assets for less than fair market value made by an individual or an individual's spouse, within the transfer of assets look-back period (or 60 months in the case of trust-related transfers) prior to the first of the month in which the individual is both in receipt of nursing facility services and determined otherwise eligible for Medicaid coverage of nursing facility services, may cause the individual to be ineligible for nursing facility services for a period of time.

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 on or after February 8, 2006, 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.

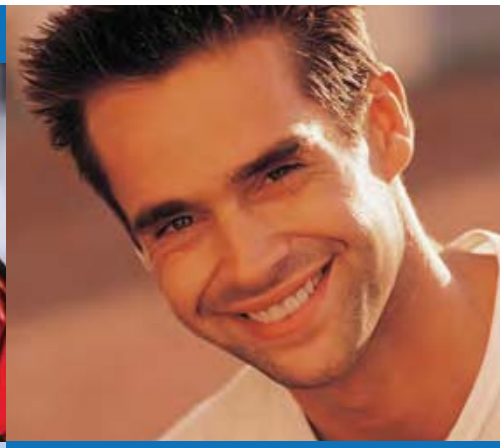
I certify under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that I must report any changes in this information within 10 days of the change.

X _____
SIGNATURE OF APPLICANT/REPRESENTATIVE

X _____
DATE SIGNED

X _____
SIGNATURE OF APPLICANT'S SPOUSE

X _____
DATE SIGNED



Health Insurance APPLICATION

access NY health care

for Children, Adults and Families

Medicaid

Child Health Plus

family health plus

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 Facilitated Enrollers 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 household 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, Family Health Plus, Child Health Plus, 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. If you are applying ONLY for children or if you are a pregnant woman applying alone, you must complete only **Sections A through G and Sections I and J.** Other applicants must complete all sections.

If you are 65 years old or older, certified blind, certified disabled, or institutionalized and applying for coverage of nursing home care, you must **also complete Supplement A.** The supplement includes questions about your resources, such as money in the bank or property you own.

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

HOW TO GET HELP When applying for public health insurance, you **DO NOT** need to visit your local department of social services or a Facilitated Enroller for an interview, but you **MAY** come in or contact a Facilitated Enroller for help filling out this application. **You can get a list of Facilitated Enrollers where you got this application, or by calling 1-800-698-4543. ALL HELP IS FREE.**
(1-877-898-5849 TTY line for the hearing impaired)

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 Household 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 maiden name (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. We also need, for each person applying, his/her mother's full maiden name (first and last name). This information may be used to obtain proof of the applicant's birth date under certain circumstances.

- **Is this person pregnant?** If so, when is her baby due to be born? This information helps us determine the size of your family. A pregnant woman 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, brother, sister, niece, nephew, etc).
- **Public Health Coverage.** If you or anyone who lives with you is already enrolled or was previously enrolled in Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or any other form of public assistance such as Food Stamps, we need to know. Also, tell us the identification number on the New York State Benefit Identification Card or plan identification card for Child Health Plus.
- **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. Pregnant women do not have to complete this question. To be eligible for health insurance, other persons age 19 and over must be U.S. citizens or be in an eligible immigration category. We need to see either original documentation of U.S. citizenship and identity, or certified copies of these documents. 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.

  Effective July 1, 2010, citizen children who provide their Social Security Number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

  Children who are New York State residents and do not have other health insurance are eligible, regardless of their immigration status.

PUBLIC CHARGE INFORMATION

The United States Citizenship and Immigration Services (USCIS) has stated that enrollment in Medicaid, Family Health Plus, Child Health Plus or the Family Planning Benefit Program CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member, or travel in and out of the country. This is not true if Medicaid pays for long-term care in a place such as a nursing home or psychiatric hospital.

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

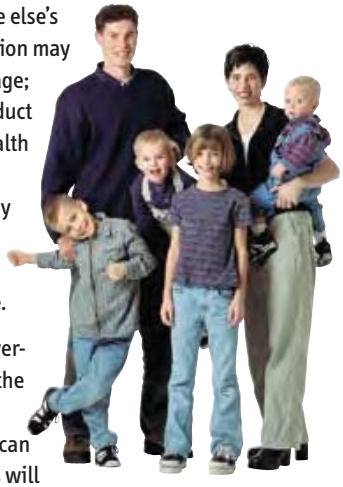
- **Race/Ethnic Group.** This information is optional and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race or ethnic background. You may pick more than one.

SECTION C Household 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. This information may affect their eligibility for coverage; 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.



Some children who had employer-based health insurance within the past six months may be subject to a waiting period before they can enroll in Child Health Plus. This will depend on your household income and the reason your children lost employer-based coverage.

NOTE: State Health Benefits Plans provide health insurance coverage through the New York State Health Insurance Program (NYSHIP). Coverage is offered to employees/retirees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate in NYSHIP. If you are not sure, check with your employer. If your child has access to State Health Insurance Benefits through NYSHIP, he/she will be ineligible for Child Health Plus coverage.

We may be able to help pay for health insurance premiums if you have or can get insurance through your job. We will need to gather more information about the insurance and will mail an insurance questionnaire to you.

SECTION E Housing Expenses

Write in your monthly cost of housing. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes in the 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. 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 a Facilitated Enroller. 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.

MORE INSTRUCTIONS ON BACK ▶

SECTION H Parent or Spouse Not Living in the Household 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.**
- **Pregnant women do not have to answer these questions until 60 days after the birth of their 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 parents are not willing to provide this information, the applying child may still be eligible for Medicaid or Child Health Plus.

SECTION I Health Plan Selection

What is a Health Plan? Applying for programs through Access NY Health Care may mean you get your health care coverage through a Managed Care plan. When you join a plan, you choose one doctor (Primary Care Provider or PCP) from that plan to take care of your regular needs. If you want to keep the doctor you have, you need to pick the plan that works with your doctor. Managed Care health plans focus on preventive care so small problems do not become big ones. If you need a specialist, your PCP will refer you to one.

Who Must Choose a Health Plan? People who are eligible for Family Health Plus and Child Health Plus **MUST** choose a health plan to get medical care. **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 and Family Health Plus, 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 NYSDOH website at **www.health.state.ny.us.** 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 in a county that does not require people on Medicaid to join a health plan, you will still be enrolled in the health plan you choose if it provides Medicaid, 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.

For Child Health Plus:

For information about Child Health Plus plans, call **1-800-698-4543.**

Child Health Plus Premium

There are no premiums for Medicaid, or Family Health Plus. There may be a monthly premium for Child Health Plus. Use the enclosed chart to determine if you need to pay a premium based on your monthly income. You must include the first month's premium with the completed application or your child will not be enrolled.

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.

State of New York
Department of Health

APPLICATION FOR PARTICIPATION IN THE
OPWDD HOME AND COMMUNITY BASED SERVICES WAIVER

Name of Applicant: _____

Current Address: _____

Social Security #: _____ Date of Birth: _____

Medicaid #: County:

☐ Check here if not currently enrolled in Medicaid.

I am requesting participation in the Home and Community Based Services Waiver administered by the New York State Office for People With Developmental Disabilities. I understand that approval will be based on my choice of Home and Community based services in preference to care in an Intermediate Care Facility for the Mentally Retarded and on evidence of:

1 developmental disability;
2 eligibility for admission to an Intermediate Care Facility for the Mentally Retarded;
3 eligibility for Medicaid enrollment;
4 availability of appropriate community based services; and
5 appropriate living arrangement

Date of stated intent to apply for HCBS waiver services: _____

Applicant Signature: _____

Applicant Name (Print): _____

Assisted by (Signature): _____

Assisted by (Print): _____

Address: _____

Telephone Number: Date:

DOCUMENTATION OF CHOICES

A) *SELECTION OF HCBS WAIVER:*

I _____(applicant), have been informed that I am eligible for care provided through either an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Home and Community Based Services (HCBS). My choice is indicated below.

_____ I have chosen HCBS _____ I have not chosen HCBS

B) *SELECTION OF SERVICE COORDINATOR:*

Service coordinator* selected:

Name: _____

Provider Agency: _____

Address: _____

_____

Phone: _____

*An approved service coordinator is one who meets Waiver Service Coordinator qualifications.

C) *ASSURANCE OF INFORMED CHOICE:*

_____ (Service Coordinator), has informed me of all the available options** with regard to service provider(s), including service coordination services.

** Applicant has the right to exercise changes in choice at any time.

D) *SIGNATURES:*

_____ _____
(Applicant Signature/Date) (Service Coordinator Signature/Date)

_____ _____
(Advocate Signature/Date) (DDSO Representative Signature/Date)

HCBS WAIVER

PRELIMINARY INDIVIDUALIZED SERVICE PLAN

(First 60 Days of Waiver Enrollment)

Name: _____ Date: _____

Individual Profile:

_____

_____

_____

_____

Appropriate Living Arrangement (Family Care, Own Home, IRA, Community Residence)

_____

_____

_____

_____

Briefly describe each activity, support or service. Include name and type of provider, frequency, duration and effective date.

Natural Supports (Friends, Family, Neighbors)

_____

_____

_____

_____

Community Resources (Community Associations/ Centers/Organizations, Churches, Schools, Volunteer Services, Senior Citizens Centers)

_____

_____

_____

_____

_____

Medicaid State Plan Services (See Medicaid State Plan Services below)

_____

_____

_____

_____

Federal or State Agency Funded Resources (VESID, State Office for the Aging, HUD, etc.)

_____

_____

_____

_____

Medicaid State Plan Services: Audiological, Clinic, Day Treatment, Dental, Durable Medical Equipment, Home Health Care, Hospital, Laboratory, Occupational Therapy, Personal Care, Pharmacy, Physical Therapy, Physician, Transportation, Other.

HCBS WAIVER
PRELIMINARY INDIVIDUALIZED SERVICE PLAN
(First 60 Days of Waiver Enrollment)
(continued...)

Waiver Services Requested (See Waiver Services below)

_____
_____
_____
_____
_____
_____

Other Services or OMRDD Supports

_____
_____
_____
_____
_____

SIGNATURES:

Waiver Applicant: _____ Date: _____

Advocate: _____ Date: _____

Service Coordinator: _____ Date: _____
(If Available)

PISP Author*: _____ Date: _____

Waiver Services: Service Coordination, Residential Habilitation, Day Habilitation, Prevocational Services, Supported Employment, Residential Respite, Hourly Respite, Environmental Modifications, Adaptive Devices.

*: If PISP is completed by someone other than the Consumer's Service Coordinator, that person should sign and date this form.

SSI Benefit Levels Chart effective January 1, 2014 (reflects the 1.5% federal COLA for January 2014)

Fed L/A Code	State Supp Code	New York State Living Arrangement	Individual			Couple		
			Federal	State	TOTAL [1]	Federal	State	TOTAL [1]
A	A	**Living Alone**	$721	$87	**$808**	$1, 082	$104	**$1,186**
A, C (B)	B (F)	**Living With Others** (Living in the Household of Another) [2]	721 (480.67)	23	**744 (503.67)**	1,082 (721.34)	46	**1,128 (767.34)**
A	C	**Congregate Care Level 1 - *Family Care*** ❑ OCFS certified Family Type Homes for Adults ❑ OMH or OPWDD certified Family Care Homes						
		NYC, Nassau, Rockland, Suffolk and Westchester Counties	721	266.48	**987.48**	1,082	892.96	**1,974.96**
		Rest of State	721	228.48	**949.48**	1,082	816.96	**1,898.96**
A	D	**Congregate Care Level 2 - *Residential Care*** ❑ OMH or OMRDD certified Community Residences, Individualized Residential Alternatives and OASAS certified Chemical Dependence Residential Services						
		NYC, Nassau, Rockland, Suffolk and Westchester Counties	721	435	**1,156**	1,082	1,230	**2,312**
		Rest of State	721	405	**1,126**	1,082	1,170	**2,252**
A	E	**Congregate Care Level 3 – *Enhanced Residential Care*** ❑ DOH certified Adult Homes and Enriched Housing programs ❑ OPWDD certified Schools for the Mentally Retarded	721	694	**1,415**	1,082	1,748	**2,830**
D	Z	**Title XIX (Medicaid certified) Institutions** [3]	30	0 [4]	**30** [4]	60	0 [4]	**60** [4]
A	Z	(see below) [5]	721	0	**721**	1,082	0	**1,082**

Minimum Personal Needs Allowances

- ❑ Congregate Care Level 1 - $139
- ❑ Congregate Care Level 2 - $160
- ❑ Congregate Care Level 3 - $190

Limits on Countable Resources

- ❑ Individuals $2,000
- ❑ Couples $3,000

Revised 4 Nov 2014

Statutory References: Chap. 57 of L. 2013

[1] The combined federal and State SSI benefit provided to eligible individuals and eligible couples with no countable income.

[2] The *Living With Others* category includes recipients whose federal benefit has been reduced by the "value of the 1/3 reduction" (VTR) due to the federal determination that they are both: *a)* living in someone else's household, *and b)* receiving some amount of free or subsidized food and shelter (room and board).

[3] Applies when an SSI recipient is residing in a medical facility, is not expected to return home within 90 days, and Medicaid is paying for at least 50% of the cost of care.

[4] Recipients in nursing homes licensed by DOH receive an additional monthly grant of $25 issued by OTDA called a State Supplemental Personal Needs Allowance (SSPNA). Residents of other medical facilities receive an SSPNA of $5.

[5] This zero federally-administered State supplement applies: a) when an SSI recipient is residing in a private medical facility and Medicaid is paying for less than 50% of the cost of care, or b) when a Recipient resides in certain publicly operated residential facilities serving 16 or fewer residents, or c) while a recipient resides in a public emergency shelter for 6 calendar months during a 9 month period.

SOCIAL SECURITY ADMINISTRATION ☐ TEL

Form Approved
OMB No. 0960-0229

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)

Note: Social Security Administration staff or others who help people apply for SSI will fill out this form for you.

Do Not Write in This Space
DATE STAMP

I am/We are applying for Supplemental Security Income and any federally administered state supplementation under Title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under Title XIX of the Social Security Act.

Filing Date (month, day, year)

☐ **Receipt** ☐ **Protective**

☐ **FS-SSA/APP** ☐ **FS-REFERRED**

Preferred Language
Written: **Spoken:**

TYPE OF CLAIM ☐ Individual ☐ Individual with Ineligible Spouse ☐ Couple ☐ Child ☐ Child with Parents

PART I--BASIC ELIGIBILITY-- Answer the questions below beginning with the first moment of the filing date month.

1. (a) First Name, Middle Initial, Last Name | Sex ☐ Male ☐ Female | Birthdate (month, day, year) | Social Security Number

(b) Did you ever use any other names (including maiden name) or any other Social Security Numbers? ☐ YES Go to (c) ☐ NO Go to (d)

(c) Other Name(s) | Other Social Security Number(s) used

(d) If you are also filing for Social Security Benefits, go to #2; otherwise complete the following:

Mother's Maiden Name: Father's Name: Go to #2

2. Applicant's Mailing Address (Number & Street, Apt. No. P.O. Box, Rural Route)

City and State | ZIP Code | County

3. Claimant's Residence Address (If different from applicant's mailing address)

City and State | ZIP Code | County

4. **DIRECT DEPOSIT PAYMENT ADDRESS (FINANCIAL INSTITUTION)**

Routing Transit Number | Account Number | ☐ Checking ☐ Savings | ☐ Enroll in Direct Express ☐ Direct Deposit Refused

5.	(a) Are you married?	☐ YES Go to (b)	☐ NO Go to #6
	(b) Date of marriage: (month, day, year)		
	(c) Spouse's Name (First, middle initial, last)	Birthdate (month, day, year)	Social Security Number
	(d) Did your spouse ever use any other names (including maiden name) or Social Security Numbers?	☐ YES Go to (e)	☐ NO Go to (f)
	(e) Other Name(s)	Other Social Security Number(s) Used	
	(f) Are you and your spouse living together?	☐ YES Go to #6	☐ NO Go to (g)
	(g) Date you began living apart : (month, day, year)		
	(h) Address of spouse or name of someone who knows where spouse is. (Complete only if spouse is age 65, blind or disabled.)		

		You	Your Spouse, if filing
6.	(a) Have you had any other marriages? If never married, check this box ☐	☐ YES Go to (b) ☐ NO Go to #7	☐ YES Go to (b) ☐ NO Go to #7

(b) Give the following information about your former spouse. If there was more than one former marriage, show the remaining information in Remarks and go to #4.

	YOU	YOUR SPOUSE
FORMER SPOUSE'S NAME (including maiden name)		
BIRTHDATE (month, day, year)		
SOCIAL SECURITY NUMBER		
DATE OF MARRIAGE (month, day, year)		
DATE MARRIAGE ENDED (month, day, year)		
HOW MARRIAGE ENDED		

		You	Your Spouse
7.	If you are filing for yourself, go to (a); if you are filing for a child, go to (e).		
	(a) Are you unable to work because of illnesses, injuries or conditions?	☐ YES Go to (b) ☐ NO Go to #8	☐ YES Go to (b) ☐ NO Go to #7
	(b) Enter the date you became unable to work.	(month, day, year)	(month, day, year)
	(c) What are your illnesses, injuries or conditions?		
		You Go to (d)	**Your Spouse** Go to (d)

7. (d) If you were unable to work because of illnesses, injuries, or conditions before you were age 22, do you have a parent who is age 62 or older, unable to work because of illnesses, injuries or conditions, or deceased?

☐ YES Parent's Name: _____

Social Security Number: _____

Address: _____

☐ NO Go to #8

(e) When did the child become disabled? (month, day, year) Go to (f)

(f) What are the child's disabling illnesses, injuries or conditions? Go to (g)

(g) Does the child have a parent(s) who is age 62 or older, unable to work because of illness, injuries, or conditions, or deceased?

☐ YES Parent's Name: _____

Social Security Number: _____

Address: _____

☐ NO Go to #8

8.

Birthplace	City	State	Country (if other than the U.S.)
You			
Your Spouse, if filing			Go to #9

		You		Your Spouse, if filing	
9.	Are you a United States citizen by birth?	☐ YES Go to #15	☐ NO Go to #10	☐ YES Go to #15	☐ NO Go to #10
10.	Are you a naturalized United States citizen?	☐ YES Go to #15	☐ NO Go to #11	☐ YES Go to #15	☐ NO Go to #11
11.	(a) Are you an American Indian born outside the United States?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)

(b) Check the block that shows your American Indian status.

You	Your Spouse, if filing
☐ American Indian born in Canada Go to #15	☐ American Indian born in Canada Go to #15
☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #15	☐ Member of a Federally recognized Indian Tribe; Name of Tribe Go to #15
☐ Other American Indian Explain in Remarks, then Go to (c)	☐ Other American Indian Explain in Remarks, then Go to (c)

11. (c) Check the block below that shows your current immigration status

You	Your Spouse, if filing
☐ Amerasian Immigrant Go to #12	☐ Amerasian Immigrant Go to #12
☐ Lawful Permanent Resident Go to #12	☐ Lawful Permanent Resident Go to #12
☐ Refugee Date of entry: Go to #14	☐ Refugee Date of entry: Go to #14
☐ Asylee Date status granted: Go to #14	☐ Asylee Date status granted: Go to #14
☐ Conditional Entrant Date status granted: Go to #14	☐ Conditional Entrant Date status granted: Go to #14
☐ Parolee for One Year Go to #14	☐ Parolee for One Year Go to #14
☐ Cuban/Haitian Entrant Go to #14	☐ Cuban/Haitian Entrant Go to #14
☐ Deportation/Removal Withheld Date: Go to #14	☐ Deportation/Removal Withheld Date: Go to #14
☐ Other Explain in Remarks, then Go to (d)	☐ Other Explain in Remarks, then Go to (d)

(d) If you have status, or have applied for status as the spouse, child, or parent of a child of a US citizen, or lawfully admitted permanent resident alien, Go to #13; otherwise Go to #15.

12. If you are lawfully admitted for permanent residence:

	You (month, day, year)	Your Spouse (month, day, year)
(a) Date of Admission		
(b) Was your entry into the United States sponsored by any person or promoted by an institution or group?	☐ YES Go to (c) ☐ NO Go to (d)	☐ YES Go to (c) ☐ NO Go to (d)

(c) Give the following information about the person, institution, or group, then Go to (d):

Name	Address	Telephone Number
		( ) -

(d) What was your immigration status, if any, before adjustment to lawful permanent resident?	You	Your Spouse, if filing
	Status:	Status:
	(month, day, year) From: To:	(month, day, year) From: To: Go to (e)
(e) If filing as an adult, did your parents ever work in the United States before you were age 18?	☐ YES Go to (f) ☐ NO Go to #14	☐ YES Go to (f) ☐ NO Go to #14

(f) Name and Social Security Number of parent(s) who worked.

Name	Social Security Number
Name	Social Security Number

		You	Your Spouse, if filing
13.	(a) Have you, your child or your parent, been subjected to battery or extreme cruelty while in the United States?	☐ YES Go to (b) ☐ NO Go to #15	☐ YES Go to (b) ☐ NO Go to #15
	(b) Have you, your child, or your parent filed a petition with the Department of Homeland Security for a change in immigration status because of being subjected to battery or extreme cruelty?	☐ YES Go to #14 ☐ NO Go to #15	☐ YES Go to #14 ☐ NO Go to #15
14.	Are you, your spouse, or parent an active duty member or a veteran of the armed forces of the United States?	☐ YES Explain in #60 (b), then Go to #15 ☐ NO Go to #15	☐ YES Explain in #60 (b), then Go to #15 ☐ NO Go to #15
15.	(a) When did you first make your home in the United States?	(month, day, year)	(month, day, year)
	(b) Have you lived outside of the United States since then?	☐ YES Go to (c) ☐ NO Go to #16	☐ YES Go to (c) ☐ NO Go to #16
	(c) Give the dates of residence outside the United States.	(month, day, year) From: To:	(month, day, year) From: To:
16.	(a) Have you been outside the United States (the 50 states, District of Columbia and Northern Mariana Islands) 30 consecutive days prior to the filing date?	☐ YES Go to (b) ☐ NO Go to #17	☐ YES Go to (b) ☐ NO Go to #17
	(b) Give the date (month, day, year) you left the United States and the date you returned to the United States.	Date Left: Date Returned:	Date Left: Date Returned:
	IF YOU ARE FILING ON BEHALF OF YOUR CHILD, GO TO #17. IF YOU ARE MARRIED AND YOUR SPOUSE IS NOT FILING FOR SUPPLEMENTAL SECURITY INCOME AND YOU LIVED TOGETHER AT ANY TIME SINCE THE FIRST MOMENT OF THE FILING DATE MONTH, GO TO #17; OTHERWISE GO TO #18.		
17.	(a) Is your spouse/parent the sponsor of an alien who is eligible for supplemental security income?	☐ YES Go to (b) ☐ No Go to #18	
	(b) Eligible Alien's Name	Eligible Alien's Social Security Number Go to #18	
18.	(a) Do you have any unsatisfied felony warrants for your arrest?	**You** ☐ YES Go to (b) ☐ NO Go to #19	**Your Spouse, if filing** ☐ YES Go to (b) ☐ NO Go to #19
	(b) In which state or country was this warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES Go to (d) ☐ NO Go to #19	☐ YES Go to (d) ☐ NO Go to #19
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)
19.	(a) Do you have any unsatisfied Federal or State warrants for violating the conditions of probation or parole?	**You** ☐ YES Go to (b) ☐ NO Go to #20	**Your Spouse, if filing** ☐ YES Go to (b) ☐ NO Go to #20

19.			
	(b) In which state or country was the warrant issued?	Name of State/Country Go to (c)	Name of State/Country Go to (c)
	(c) Was the warrant satisfied?	☐ YES Go to (d) ☐ NO Go to #20	☐ YES Go to (d) ☐ NO Go to #20
	(d) Date warrant satisfied	(month, day, year)	(month, day, year)

PART II - LIVING ARRANGEMENTS - The questions in this section refer to the signature date.

20.	Check the block which best describes your present living situation:	
	☐ Household	Since (month, day, year) Go to #25
	☐ Non-Institutional Care	Since (month, day, year) Go to #23
	☐ Institution	Since (month, day, year) Go to #21
	☐ Transient or homeless	Since (month, day, year) Go to #38

INSTITUTION

21.	Check the block that identifies the type of institution where you currently reside, then Go to #22:	
	☐ School	☐ Rehabilitation Center
	☐ Hospital	☐ Jail
	☐ Rest or Retirement Home	☐ Other (Specify)
	☐ Nursing Home	

22.	Give the following information about the INSTITUTION:
	(a) Name of institution:
	(b) Date of admission:
	(c) Date you expect to be released from this institution: Go to #38

NON-INSTITUTIONAL CARE

23.	Check the block that best describes your current residence, then Go to #24:		
	☐ Foster Home	☐ Group Home	☐ Other (Specify)

24.	Give the following information about your Noninstitutional Care:
	(a) Name of facility where you live:

24.	(b) Name of placing agency	Address	Telephone Number
			( ) -

(c) Does this agency pay for your room and board?

☐ YES Go to #38 ☐ NO If NO, who pays?

Go to #38

HOUSEHOLD ARRANGEMENTS

25. Check the block that describes your current residence, then Go to #26:

☐ House	☐ Mobile Home
☐ Apartment	☐ Houseboat
☐ Room (private home)	☐ Other (Specify)
☐ Room (commercial establishment)	

26. Do you live alone or only with your spouse? ☐ YES Go to #28 ☐ NO Go to #27

27. (a) Give the following information about everyone who lives with you:

Name	Relationship	Public Assistance		Sex		Birthdate mm/dd/yy	Blind or Disabled		If Under 22				Social Security Number
									Married		Student		
		YES	NO	M	F		YES	NO	YES	NO	YES	NO	

If anyone listed is under age 22 and not married, Go to (b); otherwise, Go to #28.

27.	(b) Does anyone listed in 27(a) who is under age 18, OR between ages 18-22 and a student, receive income?	YES Go to (c)	NO Go to #28

(c) Child Receiving Income	Source and Type	Monthly Amount
		$
		$
		$
		$
		$
		$

28.	(a) Do you (or does anyone who lives with you) own or rent the place where you live?	YES Go to #29	No Go to (b)

(b) Name of person who owns or rents the place where you live	Address	Telephone Number
		( ) -

(c) If you live alone or only with your spouse, and do not own or rent, Go to #38; otherwise, Go to #32.

29.	(a) Are you (or your living with spouse) buying or do you own the place where you live?	YES Go to (c)	No If you are a child living with your parent(s) Go to (b); otherwise Go to #30
	(b) Are your parent(s) buying or do they own the place where you live?	YES Go to (c)	NO Go to #30

(c) What is the amount and frequency of the mortgage payment?

Amount: $ Frequency of Payment: Go to (d)

(d) If you are a child living only with your parents, or only with your parents and their other children who are subject to deeming, or with others in a public assistance household, or living alone or with your spouse, Go to #38; otherwise Go to #32.

30.	(a) Do you (or your living with spouse) have rental liability for the place where you live?	YES Go to (d)	NO If you are a child living with your parent(s) Go to (b); otherwise Go to (c)
	(b) Does your parent(s) have rental liability?	YES Go to (d)	NO Go to (c)

30. (c) Does anyone who lives with you have rental liability for the place where you live?

☐ YES Give name of person with rental liability: _____ Go to #31

☐ NO Give name of person with home ownership: _____ Go to #32

(d) What is the amount and frequency of the rent payment?

Amount: $ Frequency of Payment:

Go to #31

31. (a) Are you (or anyone who lives with you) the parent or child of the landlord or the landlord's spouse? ☐ YES Go to (b) ☐ NO Go to (c)

(b) Name of person related to landlord or landlord's spouse	Relationship	Name and address of landlord (include telephone number and area code, if known):

(c) If you are a child living only with your parents, or only with your parents and their other children who are subject to deeming, or with others in a public assistance household, or living alone or with your spouse, Go to #38.

32. (a) Does anyone living with you contribute to the household expenses? (NOTE: See list of household expenses in #37) ☐ YES Go to (b) ☐ NO Go to #33

(b) Amount others contribute: $

Go to #33

33. (a) Do you eat all your meals out? ☐ YES Go to #34 ☐ NO Go to (b)

(b) Do you buy all your food separately from other household members: ☐ YES Go to #34 ☐ NO Go to #34

34. Do you contribute to household expenses?

☐ YES Average Monthly Amount: $ _____ Go to #35

☐ NO Go to #35

35. (a) Do you have a loan agreement with anyone to repay the value of your share of the household expenses? ☐ YES Go to (b) ☐ NO Go to #35(d)

(b) Give the name, address and telephone number of the person with whom you have a loan agreement :

(c) Will the amount of this loan cover your share of the household expenses? ☐ YES Go to #38 ☐ NO Go to (d)

(d) **If you contribute** toward household expenses and you answered "NO" to both 33(a) & (b), Go To #36. If you answered "YES" to either 33(a) or 33(b), Go to #37.

If you do not contribute toward household expenses, go to #38.

36. (a) Is part or all of the amount in #34 just for food?

☐ YES Give Amount: $ _____ Go to (b) ☐ NO Go to (b)

(b) Is part or all of the amount in #34 just for shelter?

☐ YES Give Amount: $ _____ Go to #37 ☐ NO Go to #37

37. What is the average monthly amount of the following household expenses:
(Show average over the past 12 months unless you have been residing at your present address less than 12 months. If so, show average for the months you have resided at your present address.)

CASH EXPENSES	AVERAGE MONTHLY AMOUNT
Food (complete only if #33(a) & (b) are answered NO)	$
Mortgage or Rent	$
Property Insurance (if required by mortgage lender)	$
Real Property Taxes	$
Electricity	$
Heating Fuel	$
Gas	$
Sewer	$
Garbage Removal	$
Water	$
TOTAL	$ Go to #38

38. (a) Does anyone who does NOT LIVE with you pay for, or provide you or your household (if applicable), any of your food or shelter items?

☐ YES Name of Provider (Person or Agency) _____

List of Items _____

Monthly Value: $ _____

☐ NO Go to (b)

(b) Does anyone who does NOT LIVE with you give you, or your household (if applicable), money to pay for any of your or your household's food or shelter items?

☐ YES Name of Provider (Person or Agency) _____

List of Items _____

Monthly Value: $ _____

☐ NO Go to #39

39. (a) Has the information given in #20-38 been the same since the first moment of the filing date month?

☐ YES Go to (b) ☐ NO Explain in Remarks, then Go to (b)

(b) Do you expect any of this information to change?

☐ YES Explain in Remarks, then Go to #40 ☐ NO Go to #40

PART III - RESOURCES - The questions in this section pertain to the first moment of the filing date month.

40. (a) Do you own, or does your name appear (alone or with any other person's name) on the title of any vehicles (auto, truck, motorcycle, camper, boat, etc.)?

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (b)	Go to #41	Go to (b)	Go to #41

40.

(b) Owner's Name	Description (Year, Make & Model)	Used For	Current Market Value	Amount Owed
			$	$
			$	$
			$	$
			$	$

41. (a) Do you own or are you buying any life insurance policies?

You		Your Spouse	
☐ YES	☐ NO	☐ YES	☐ NO
Go to (b)	Go to #42	Go to (b)	Go to #42

(b)	Owner's Name	Name of Insured	Name & Address of Insurance Company	Policy Number
Policy (#1)				
Policy (#2)				
Policy (#3)				

	Face Value	Cash Surrender Value	Date of Purchase	Dividends		Accumulations	
				YES	NO	YES	NO
Policy (#1)	$	$					
Policy (#2)	$	$					
Policy (#3)	$	$					

(c) Loans Against Policy? ☐ YES ☐ NO

Policy Number: _____

Amount: $_____ Go to #42

42. (a) Do you (either alone or jointly with any other person) own any:

	You		Your Spouse	
	YES	NO	YES	NO
Life estates or ownership interest in an unprobated estate?				
Items acquired or held for their value as an investment?	☐	☐	☐	☐

42. (b) Give the following information for any "Yes" answer in #42(a); otherwise, Go to #43.

Owner's Name	Name of Item	Value	Amount Owed	Give Name & Address of Bank or Other Organization
		$	$	
		$	$	
		$	$	
		$	$	

43. (a) Do you own, or does your name appear on (either alone or with any other person's name) any of the following items?

	You		Your Spouse	
	YES	NO	YES	NO
Cash at home, with you, or anywhere else				
Financial Institution Accounts				
Checking				
Savings				
Credit Union				
Christmas Club				
Time Deposits/Certificates of Deposit				
Individual Indian Money Account				
Other (Including IRAs and Keough Accounts)				

(b) If all the items in #43(a) are answered "NO", Go to #44. For any "YES" answer, give the following information:

Owner's/Trustee's Name	Name of Item	Value	Name & Address of Bank or Other Organization	Identifying Number
		$		
		$		
		$		

44.	(a) Do you give us permission to obtain any financial records from any financial institution?	You		Your Spouse, if filing	
		☐ YES	☐ NO	☐ YES	☐ NO
		Go to (b)	Go to (b)	Go to (b)	Go to (b)

(b) Do you own or does your name appear on any of the following items:	You		Your Spouse	
	YES	NO	YES	NO
Stocks or Mutual Funds				
Bonds (Including U.S. Savings Bonds)				
Promissory Notes				
Trusts				
Other items that can be turned into cash				

(c) If all the items in #44(b) are answered "NO", Go to #45. For any "YES" answer, give the following information:

Owner's/Trustee's Name	Name of Item	Value	Name & Address of Bank or Other Organization	Identifying Number
		$		
		$		
		$		
		$		

45.	(a) Do you own, or does your name appear (alone or with any other person's name) on any land, houses, buildings, real property, property in foreign country, equipment, mineral rights, items in a safe deposit box, assets set aside for emergencies or heirs, or any other property of any kind that has not been shown anywhere else on the application	You		Your Spouse	
		☐ YES	☐ NO	☐ YES	☐ NO
		Go to (b)	Go to #46	Go to (b)	Go to #46

(b) Describe the property (including size, location, and how it is used. If the property is not used now, when was it last used? Do you plan to use the property in the future?

Item #1

Item #2

45.

Owner's Name	Estimated Current Market Value	Tax Assessed Value	Mortgage	Owed on Item
	$	$	$	$
	$	$	$	$
	$	$	$	$

46.

(a) Have you or your spouse acquired any assets since the first moment of the filing date month?	☐ YES Go to (b)	☐ NO Go to (c)
(b) Explain:		
(c) Has there been any increase or decrease in the value of you or your spouse's resources since the first moment of the filing date month?	☐ YES Go to (d)	☐ NO Go to #47
(d) Explain:		

47.

	You	Your Spouse
(a) Have you or your spouse sold, transferred title, disposed of or given away, any money or other property, (including money or property in foreign countries), since the first moment of the filing date month or within the 36 months prior to the filing date month?	☐ YES ☐ NO Go to (b)	☐ YES ☐ NO Go to (b)
(b) If you co-owned any money or property with another person(s), did you or any co-owner sell, transfer, or give away any co-owned money or property within the 36 months prior to the filing date month?	☐ YES ☐ NO	☐ YES ☐ NO

IF YOU ANSWERED "YES" TO (a) OR (b), GO TO (c). IF "NO" TO BOTH, GO TO #48.

(c)	OWNER'S/CO-OWNERS NAME	DESCRIPTION OF PROPERTY	DATE OF DISPOSAL
ITEM #1			
ITEM #2			
ITEM #3			
	NAME AND ADDRESS OR PURCHASER OR RECIPIENT	**RELATIONSHIP TO OWNER**	**VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT**
ITEM #1			$

47.				
	ITEM #2			$
	ITEM #3			$
		SALES PRICE OR OTHER CONSIDERATION	**ARE OTHER CONSIDERATION OR PROCEEDS EXPECTED? EXPLAIN.**	**DO YOU STILL OWN PART OF THE PROPERTY?**
	ITEM #1			
	ITEM #2			
	ITEM #3			
		SOLD ON OPEN MARKET?	**GIVEN AWAY?**	**TRADED FOR GOODS/SERVICES?**
	ITEM #1	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
	ITEM #2	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**
	ITEM #3	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

48.		**You**	**Your Spouse**
	(a) Do you have any assets set aside for burial expenses such as burial contracts, trusts, agreements, or anything else you intend for your burial expenses? Include any items mentioned in #41 and #43-47.	☐ YES Go to (b) ☐ NO Go to #49	☐ YES Go to (b) ☐ NO Go to #49

(b) DESCRIPTION (Where appropriate, give name & address of organization and account/ policy number.)	VALUE	WHEN SET ASIDE (month, day, year)	OWNER'S NAME
Item 1	$		
Item 2	$		

FOR WHOSE BURIAL	IS ITEM IRREVOCABLE?	WILL INTEREST EARNED OR APPRECIATION IN VALUE REMAIN IN THE BURIAL FUND?
Item 1	☐ YES ☐ NO	☐ YES Go to #49 ☐ NO Explain in (c)
Item 1	☐ YES ☐ NO	☐ YES Go to #49 ☐ NO Explain in (c)

(c) EXPLANATION

49.	(a) Do you own any cemetery lots, crypts, caskets, vaults, urns, mausoleums, or other repositories for burial or any headstones or markers?	You YES Go to (b)	 NO Go to #50	Your Spouse YES Go to (b)	 NO Go to #50

(b) Owner's Name	Description	For Whose Burial	Relationship to You or Your Spouse	Current Market Value
				$
				$
				$ Go to #50

PART IV -- INCOME

50. (a) Since the first moment of the filing date month, have you (or your spouse) received or do you (or your spouse) expect to receive income in the next 14 months from any of the following sources?	You		Your Spouse	
	YES	NO	YES	NO
State or Local Assistance Based on Need				
Refugee Cash Assistance				
Temporary Assistance for Needy Families				
General Assistance from the Bureau of Indian Affairs				
Disaster Relief				
Veteran Benefits Based on Need (Paid Directly or Indirectly as a Dependent)				
Veteran Payments Not Based on Need (Paid Directly or Indirectly as a Dependent)				
Other Income Based on Need				
Social Security				
Black Lung				
Railroad Retirement Board Benefits				
Office of Personnel Management (Civil Service)				
Pension (Foreign Military, State, Local, Private, Union, Retirement or Disability)				
Military Special Pay or Allowance				
Unemployment Compensation				

50.					
	Workers' Compensation				
	State Disability				
	Insurance or Annuity Payments				
	Dividends/Royalties				
	Rental/Lease Income Not from a Trade or Business				
	Alimony				
	Child Support				
	Other Bureau of Indian Affairs Income				
	Gambling/Lottery Winnings				
	Other Income or Support				

(b) Give the following information for any block checked YES in #50(a); otherwise, Go to #51

Person Receiving Income	Type of Income	Amount Received	Frequency of Payment	Date Expected or Received	Source (Name, Address of Person, Bank, Organization, or Company)	Identifying Number
		$				
		$				
		$				

IF YOU EVER RECEIVED SSI BEFORE, GO TO #51; OTHERWISE GO TO #52

		You		Your Spouse	
51.	Are any overpayments being collected from benefits you receive from the Social Security Administration, Railroad Retirement Board, Office of Personnel Management, Veterans' Affairs, Military Pensions, Military Special Pay Allowances, Black Lung, Workers' Compensation, or State Disability or Unemployment Benefits?	☐ YES Explain in Remarks, then Go to #52	☐ NO Go to #52	☐ YES Explain in Remarks, then Go to #52	☐ NO Go to #52
52.	Since the first moment of the filing date month, have you received or do you expect to receive any meals or other gifts which are not cash?	☐ YES Explain in Remarks, then Go to #53	☐ NO Go to #53	☐ YES Explain in Remarks, then Go to #53	☐ NO Go to #53
53.	(a) Have you (or your spouse) received wages or sick pay since the first moment of the filing date month through the current month?	☐ YES Go to (b)	☐ NO Go to (e)	☐ YES Go to (b)	☐ NO Go to (e)

(b) Name and Address of Employer (include telephone number and area code, if known)

You	**Your Spouse**
Go to (c)	Go to (c)

53. (c)

	Date last worked (month, day, year)	Date last paid (month, day, year)	Date next paid (month, day, year)
You			
Your Spouse			

(d) Total monthly wages received (before any deductions)	Your Amount $	Your Spouse's Amount $
(e) Do you (or your spouse) expect to receive any wages in the next 14 months?	**You** ☐ YES Go to (f) ☐ NO Go to #54	**Your Spouse** ☐ YES Go to (f) ☐ NO Go to #54

(f) Name and address of employer if different from #53(b) (include telephone number, if known)

You	Your Spouse

(g) Give the following information:

	RATE OF PAY	AMOUNT WORKED PER PAY PERIOD	HOW OFTEN PAID	PAY DAY OR DATE PAID	DATE LAST PAID (month, day, year)
You	$				
Your Spouse	$				

(h) Do you expect any change in wage information provided in #53(g)	**You** ☐ YES Go to (i) ☐ NO Go to #54	**Your Spouse** ☐ YES Go to (i) ☐ NO Go to #54

(i) Explain Change:

You	**Your Spouse**

54.

(a) Have you been self-employed at any time since the beginning of the taxable year in which the filing date month occurs or do you expect to be self-employed in the current taxable year?	**You** ☐ YES Go to (b) ☐ NO Go to #55	**Your Spouse** ☐ YES Go to (b) ☐ NO Go to #55

(b) Give the following information; then Go to #55

Date(s) Self-Employed	Type of Business	**Last Year's:** Gross Income $	**Last Year's:** Net Profit $	**Last Year's:** Net Loss $
Date(s) Self-Employed	Type of Business	**This Year's:** Gross Income $	**This Year's:** Net Profit $	**This Year's:** Net Loss $

		You	Your Spouse
55.	If you or your spouse are blind or disabled, do you have any special expenses that you paid which are necessary for you to work?	☐ YES Explain in Remarks; then Go to #56 ☐ NO Go to #56	☐ YES Explain in Remarks; then Go to #56 ☐ NO Go to #56
56.	(a) Does your spouse/parent who lives with you have to pay court-ordered support?	☐ YES Go to (b)	☐ NO Go to NOTE
	(b) Give amount and frequency of court-ordered support payment.	Amount: $	Frequency: Go to (c)
	(c) Give the following information about the person who receives these payments:	Name:	Address:
	NOTE: IF YOU ARE FILING AS A CHILD AND YOU ARE EMPLOYED OR AGE 18 - 22 (WHETHER EMPLOYED OR NOT), GO TO #57; OTHERWISE, GO TO #58.		
57.	(a) Have you attended school regularly since the filing date month?	☐ YES Go to (d)	☐ NO Go to (b)
	(b) Have you been out of school for more than 4 calendar months?	☐ YES Go to (c)	☐ NO Go to (c)
	(c) Do you plan to attend school regularly during the next 4 months?	☐ YES Explain absence in Remarks and Go to (d)	☐ NO Go to #58

(d) Name of School	Name of School Contact	Dates of Attendance From	To	Course of Study
	Phone Number	Hours Attending or Planning to Attend		

PART V - POTENTIAL ELIGIBILITY FOR FOOD STAMPS/MEDICAL ASSISTANCE/OTHER BENEFITS - If a California resident, Skip to #59

		You		Your Spouse, if filing	
58.	(a) Are you currently receiving food stamps?	☐ YES Go to (b)	☐ NO Go to (c)	☐ YES Go to (b)	☐ NO Go to (c)
	(b) Have you received a recertification notice within the past 30 days?	☐ YES Go to (e)	☐ NO Go to #59	☐ YES Go to (e)	☐ NO Go to #59
	(c) Have you filed for food stamps in the last 60 days?	☐ YES Go to (d)	☐ NO Go to (e)	☐ YES Go to (d)	☐ NO Go to (e)
	(d) Have you received an unfavorable decision?	☐ YES Go to (e)	☐ NO Go to #59	☐ YES Go to (e)	☐ NO Go to #59
	(e) If everyone in the household receives or is applying for SSI, Go to (f); otherwise Go to #59.				
	(f) May I take your food stamp application today?	☐ YES Go to #59	☐ NO Explain in (g)	☐ YES Go to #59	☐ NO Explain in (g)
	(g) Explanation:				

59. You may be eligible for Medicaid. However, you must help your State identify other sources that pay for medical care. Also, you must give information to help the State get medical support for any child(ren) who is your legal responsibility. This includes information to help the State determine who a child's father is. If you want Medicaid, you must agree to allow your State to seek payments from sources, such as insurance companies, that are available to pay for your medical care. This includes payments for medical care for you or any person who receives Medicaid and is your legal responsibility. The State cannot provide you Medicaid if you do not agree to this Medicaid requirement. If you need further information, you may contact your Medicaid Agency.

IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, Go to (b).

	You		Your Spouse, if filing	
(a) Do you agree to assign your rights (or the rights of anyone for whom you can legally assign rights) to payments for medical support and other medical care to the State Medicaid agency?	YES Go to (b)	NO Go to #60	YES Go to (b)	NO Go to #60
(b) Do you, your spouse, parent or stepparent have any private, group, or governmental health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid.)	YES Go to (c)	NO Go to (c)	YES Go to (c)	NO Go to (c)
(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month?	YES Go to #60	NO Go to #60	YES Go to #60	NO Go to #60

60. (a) Have you ever worked under the U.S. Social Security System? YES Go to (b) NO Go to (b)

(b) Have you, your spouse, or a former spouse (or parent if you are filing as a child) ever:	You		Your Spouse/Parent		Filed for Benefits	
	Yes	No	Yes	No	Yes	No
Worked for a railroad						
Been in military service						
Worked for the Federal Government						
Worked for a State or Local Government						
Worked for an employer with a pension plan						
Belonged to union with a pension plan						
Worked under a Social Security system or pension plan of a country other than the United States?						

(c) Explain and include dates for any "Yes" answer given in #14 or #60(a); otherwise Go to #61.

You:	Your Spouse, if filing/Your Parent, if filing as a child:

PART VI -- MISCELLANEOUS -- (Answer #61 ONLY IF YOU ARE APPLYING ON BEHALF OF SOMEONE ELSE: OTHERWISE GO TO #62.

61.

(a) Name of Person/Agency Requesting Benefits.	Relationship to Claimant	Your Social Security Number (or EIN)

(b) If SSA determines that the claimant needs help managing benefits, do you wish to be selected representative payee? YES NO (Explain in Remarks)

PART VII -- REMARKS--(You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

PART VIII -- IMPORTANT INFORMATION AND SIGNATURES

62. **IMPORTANT INFORMATION--PLEASE READ CAREFULLY**

▶Failure to report any change within 10 days after the end of the month in which the change occurs could result in a penalty deduction.

▶The Social Security Administration will check your statements and compare its records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount.

▶ We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

63. **I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

Your Signature (First name, middle initial, last name) (Sign in ink.)	Date (month, day, year)
SIGN HERE ▶	Telephone Number(s) where we can contact you during the day: ( ) -

Spouse's Signature **(Sign only if applying for payments.)** (First name, middle initial, last name) (Sign in ink.)

SIGN HERE ▶

64. If you are blind or visually impaired, check the type of mail you want to receive from us.

☐ Standard notice First Class ☐ Standard notice First-Class with a follow-up phone call ☐ Standard notice & data CD by First-Class
☐ Standard notice Certified ☐ Standard & Braille notices by First-Class ☐ Standard & large print notices ☐ Standard notice & audio CD

65. WITNESS

Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing who know you, must sign below giving their full address.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

RECEIPT FOR YOUR CLAIM FOR SUPPLEMENTAL SECURITY INCOME

Name	Social Security Number	Date
Name	Social Security Number	Date

If you have a question or something to report call:	Social Security Office you may visit or mail your request to:
( ) -	

For general information about Social Security, visit our website at www.socialsecurity.gov on the Internet.

We will process your application for Supplemental Security Income as quickly as possible. If you have trouble getting any information or records we have asked for, please contact us and we will help you.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed. If you do not get a check or notice of determination within that time, please get in touch with us.

Privacy Act Statement/ Paperwork Reduction Act Statement
Collection and Use of Personal Information

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. We will use this information to help us determine your entitlement to benefits. Furnishing us this information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on your claim, which may result in the loss of payments. We rarely use the information you supply for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Medicare benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State and local level; and,
4. To facilitate statistical research and audit activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete use of routine uses for this information is available in System of Records Notices 60-0089, Claims Folder System and 60-0050, Completed Determination-Continuing Disability Determinations. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 40 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

REPORTING RESPONSIBILITIES

The amount of a Supplemental Security Income (SSI) check is based on the information told to us. You must tell Social Security every time there is a change-while we process your application AND if you start receiving SSI.

Remember, a change may make the SSI monthly payment bigger or smaller. Report changes in income of your ineligible husband/wife or child who lives with you or your sponsor or sponsor's spouse, if you are an alien. You must also report changes in the things of value that these people own. You must also report changes in income, school attendance and marital status of ineligible children who live with you.

You must tell us about any change within 10 days after the month it happens. If you do not report changes, we may have to take as much as $25, $50, or $100 out of future checks.

HOW TO REPORT

You may make your reports:

- **By telephone at the telephone number shown above or call us toll free at 1-800-772-1213 (TTY 1-800-325-0778) or**
- **In person or**
- **By mail at the address shown above.**

CHANGES TO REPORT

WHERE YOU LIVE --You must report to Social Security if:

- You move.
- You (or your spouse) leave your household for a calendar month or longer. (For example, you enter a hospital or visit a relative.)
- You are admitted to (for a calendar month or longer), or released from, a hospital or nursing home, jail, prison, or other correctional facility or other institution.
- You leave the United States for 30 consecutive days.
- You are no longer a legal resident of the United States

HOW YOU LIVE -You must report to Social Security:

- If anyone moves into or out of your household.
- If the amount of money you pay toward household expenses changes.
- Births and deaths of any people with whom you live.
- Your spouse or former spouse dies.
- Your marital status changes:
  --You get married, separated, divorced, or your marriage is annulled.
  --You begin living with someone as husband and wife.

INCOME-You must report to Social Security if you, your spouse/your parent(s):

- Start to receive money (or checks or any other type of payment) from someone or someplace.
- Have a change in the amount of money you receive.
- Begin to receive child support payments or those payments go up or down.
- Win money from gambling or a lottery.
- Start work or stop work.
- Earn more or less money. (**Keep all paystubs** and provide them to SSA when requested.)
- Become eligible for benefits other than SSI.

HELP YOU GET FROM OTHERS -You must report to Social Security if:

- The amount of help (money or food, or payment of household expenses) you receive goes up or down.
- Someone stops helping you.
- Someone starts helping you.

THINGS OF VALUE THAT YOU OWN -You must report to Social Security if:

- The value of things that you own goes over $2000 when you add them all together ($3000 if you are married and live with your spouse).
- You sell or give any thing of value away.
- You buy or are given anything of value.

YOU ARE BLIND OR DISABLED-You must report to Social Security if:

- Your condition improves or your doctor says you can return to work.
- You go to work.

IF YOU ARE THE PARENT, STEP PARENT, OR REPRESENTATIVE PAYEE FOR A CHILD UNDER 18 - A report to Social Security must be made if:

- There is a change in any income the child, his or her parent(s), step parent, or brother(s) or sister(s) receive.
- There is a change in the student status of the child's brother(s) or sister(s).
- There is a change in his or her parents' or step parents' marriage, a change in the value of anything they own, or a change in their residence.

YOU ARE UNMARRIED AND UNDER AGE 22 - A report to Social Security must be made if:

- You start or stop school
- You get married or divorced
- You start or stop working

YOUR IMMIGRATION STATUS CHANGES-

- You must report any changes to Social Security.

YOU ARE SELECTED AS A REPRESENTATIVE PAYEE -You must report to Social Security if:

- The person for whom you receive SSI checks has any changes listed above. (You may be held liable if you do not report changes that could affect the SSI recipient's payment amount, and he/she is overpaid.)
- You will no longer be able or no longer wish to act as that person's representative payee.

IF A WARRANT HAS BEEN ISSUED FOR YOUR ARREST -You must report to Social Security if:

- Your warrant is for a crime or an attempted crime that is a felony (or, in jurisdictions that do not define crimes as felonies, a crime that is punishable by death or imprisonment for a term exceeding 1 year); or
- Your warrant is for a violation of probation or parole under Federal or State law.

SOCIAL SECURITY ADMINISTRATION **TOE 250**

Form Approved
OMB No. 0960-0014

REQUEST TO BE SELECTED AS PAYEE	FOR SSA USE ONLY								FOR SSA USE ONLY
	Name or Bene. Sym.	Program	Date of Birth	Type	Gdn.	Cus.	Inst.	Nam.	
									DISTRICT OFFICE CODE
PRINT IN INK:									STATE AND COUNTY CODE:

The name of the NUMBER HOLDER	SOCIAL SECURITY NUMBER
The name of the PERSON(S) (if different from above) for whom you are filing (the "claimant(s)")	SOCIAL SECURITY NUMBER(S)

Answer item 1 ONLY if you are the claimant and want your benefits paid directly to you.

1. I request that I be paid directly.

   CHECK HERE ☐ and answer only items 3, 5, 6, and 8 before signing the form on page 4.

I REQUEST THAT THE SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, OR SPECIAL VETERANS BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS REPRESENTATIVE PAYEE.

2. Explain why you think the claimant is not able to handle his/her own benefits.
   (In your answer, describe how he/she manages any money he/she receives now.)

   ☐ Claimant is a minor child.

3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)

4. If you are appointed payee, how will you know about the claimant's needs?
   - ☐ Live with me or in the institution I represent.
   - ☐ Daily visits.
   - ☐ Visits at least once a week.
   - ☐ By other means. Explain:

5. Does the claimant have a court-appointed legal guardian/conservator? ☐ YES ☐ NO

   IF YES, enter the legal guardian/conservator's:

   NAME _____

   ADDRESS _____

   PHONE NUMBER _____

   TITLE _____

   DATE OF APPOINTMENT _____

   Explain the circumstances of the appointment. (Use remarks if you need more space.)

6. (a) Where does the claimant live?

- ☐ Alone
- ☐ In my home (Go to (b).)
- ☐ With a relative (Go to (b).)
- ☐ With someone else (Go to (b).)
- ☐ In a board and care facility (Go to (b).)
- ☐ In a public institution (Go to (c).)
- ☐ In a private institution (Go to (c).)
- ☐ In a nursing home (Go to (c).)
- ☐ In the institution I represent (Go to (c).)

(b) Enter the names and relationships of any other people who live with the claimant.

NAME	RELATIONSHIP

(c) Enter the claimant's residence and mailing addresses (if different from yours).

Residence: Mailing: Telephone Number:

(d) Do you expect the claimant's living arrangements to change in the next year?

☐ YES ☐ NO If YES, explain what changes are expected and when they will occur. (Use Remarks if you need more space.)

7. If you are applying on behalf of minor child(ren) and you are not the parent,

Does the child(ren) have a living natural or adoptive parent? ☐ YES ☐ NO

If YES, enter: (a) Name of parent _____

(b) Address of parent _____

(c) Telephone number _____

(d) Does the parent show interest in the child? ☐ YES ☐ NO

Please explain. _____

8. List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and/or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	DESCRIBE

9. Check the block that describes your relationship to the claimant.

(a) ☐ Official of bank, agency or institution with responsibility for the person. Enter below which you represent:

- ☐ Bank
- ☐ Social Agency
- ☐ Public Official
- ☐ Institution:
  - ☐ Federal
  - ☐ State/Local
  - ☐ Private non-profit
  - ☐ Private proprietary institution. Is the institution licensed under State law? ☐ YES ☐ NO

IF (a) ABOVE CHECKED, COMPLETE ONLY QUESTIONS 10 AND 11 AND SIGN THE FORM ON PAGE 4.

(b) ☐ Parent

(c) ☐ Spouse

(d) ☐ Other Relative - Specify _____

(e) ☐ Legal Representative

(f) ☐ Board and Care Home Operator

(g) ☐ Other Individual - Specify _____

IF (b), (c), (d), or (e) ABOVE CHECKED, GO ON TO QUESTION 12

10. Does the claimant owe you/your organization any money now or will he/she owe you money in the future? ☐ YES ☐ NO

If YES, enter the amount he/she owes you/your organization, the date(s) was/will be incurred and describe why the debt was/will be incurred.

INFORMATION ABOUT INSTITUTIONS, AGENCIES AND BANKS APPLYING TO BE REPRESENTATIVE PAYEE

11. (a) Enter the name of the institution _____

(b) Enter the EIN of the institution _____

INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE

12. Enter: YOUR NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

ANY OTHER NAME YOU HAVE USED _____

OTHER SSN'S YOU HAVE USED _____

13. How long have you known the claimant? _____

14. If the claimant lives with you, who takes care of the claimant when work or other activity takes you away from home?

What is his/her relationship to the claimant?

15. (a) Main source of your income

☐ Employed (answer (b) below)
☐ Self-employed (Type of Business _____)
☐ Social Security benefits (Claim Number _____)
☐ Pension (describe _____)
☐ Supplemental Security Income payments (Claim Number _____)
☐ AFDC (County & State _____)
☐ Other Welfare (describe _____)
☐ Other (describe _____)

(b) Enter your employer's name and address:

How long have you been employed by this employer? _____

(If less than 1 year, enter name and address of previous employer in Remarks.)

16. (a) Have you ever been convicted of a felony? ☐ YES ☐ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

(b) Have you ever been convicted of any offense under federal or state law which resulted in imprisonment for more than one year? ☐ YES ☐ NO

If YES: What was the crime? _____

On what date were you convicted? _____

What was your sentence? _____

If imprisoned, when were you released? _____

If probation was ordered, when did/will your probation end? _____

17.	Do you have any unsatisfied FELONY warrants (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) for your arrest? YES NO If YES: Date of Warrant_____ State where warrant was issued_____
18.	How long have you lived at your current address? (Give Date MM/YY) _____

REMARKS: *(This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)*

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuse the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheets(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE *(Month, day, year)*
Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** ▶	Telephone number(s) at which you may be contacted during the day

Print Your Name & Title *(if a representative or employee of an institution/organization)*

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Name of County

Residence Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	Zip Code	Name of County

Witnesses are only required if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant making the request must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS *(Number and street, City, State and ZIP Code)*	ADDRESS *(Number and street, City, State and ZIP Code)*

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant DIES (Social Security entitlement ends the month before the month the claimant dies);
- the claimant MARRIES, if the claimant is entitled to child's, widow's, mother's, father's, widower's or parent's benefits, or to wife's or husband's benefits as divorced wife/husband, or to special age 72 payments;
- the claimant's marriage ends in DIVORCE or ANNULMENT, if the claimant is entitled to wife's, husband's or special age 72 payments;
- the claimant's SCHOOL ATTENDANCE CHANGES if the claimant is age 18 or over and entitled to child's benefits as a full time student
- the claimant is entitled as a stepchild and the parents DIVORCE (benefits terminate the month after the month the divorce becomes final);
- the claimant is under FULL RETIREMENT AGE (FRA) and WORKS for more than the annual limit (as determined each year) or more than the allowable time (for work outside the United States);
- the claimant receives a GOVERNMENT PENSION or ANNUITY or the amount of the annuity changes, if the claimant is entitled to husband's, widower's, or divorced spouse's benefit's;
- the claimant leaves your custody or care or otherwise CHANGES ADDRESS;
- the claimant NO LONGER HAS A CHILD IN CARE, if he/she is entitled to benefits because of caring for a child under age 16 or who is disabled;
- the claimant is confined to jail, prison, penal institution or correctional facility;
- the claimant is confined to a public institution by court order in connection WITH A CRIME.
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issue for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

IF THE CLAIMANT IS RECEIVING DISABILITY BENEFITS, YOU MUST ALSO REPORT IF:

- the claimant's MEDICAL CONDITION IMPROVES;
- the claimant STARTS WORKING;
- the claimant applies for or receives WORKER'S COMPENSATION BENEFITS, Black Lung Benefits from the Department of Labor, or a public disability benefit;
- the claimant is DISCHARGED FROM THE HOSPITAL (if now hospitalized).

IF THE CLAIMAINT IS RECEIVING SPECIAL AGE 72 PAYMENTS, YOU MUST ALSO REPORT IF:

- the claimant or spouse becomes ELIGIBLE FOR PERIODIC GOVERNMENTAL PAYMENTS, whether from the U.S. Federal government or from any State or local govenment;
- the claimant or spouse receives SUPPLEMENTAL SECURITY INCOME or PUBLIC ASSISTANCE CASH BENEFITS;
- the claimant or spouse MOVES outside the United States (the 50 States, the District of Columbia and the Northern Marian Islands).

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have a UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail, or in person.

REMEMBER:

- **payments must be used for the claimant's current needs or saved if not currently needed;**
- **you may be held liable for repayment of any payments not used for the claimant's needs or of any over payment that occured due to your fault;**
- **you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with correct accounting;**
- **to tell us as soon as you know you will no longer be able to act as representative payee or the claimant no longer needs a payee.**

Keep in mind that benefits may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

A REMINDER TO PAYEE APPLICANTS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for Social Security benefits on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you — or someone for you — should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

THE PRIVACY ACT

Sections 205(a) and 205(j) of the Social Security Act, as amended, authorize us to collect the information on this form. The information you provide will be used to determine if you are qualified to serve as a representative payee. Your response is voluntary. However, failure to provide the requested information will prevent us from making a determination to select you as representative payee.

We rarely use the information provided on this form for any purpose other than for making representative payee selections. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form (1) to enable a third party or an agency to assist Social Security in evaluating payee applicants' suitability to be named representative payees; (2) to claimants or other individuals when needed to pursue a claim for recovery of misapplied or misused benefits; (3) to comply with Federal laws requiring the disclosure of the information from our records; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is contained in our System of Records Notice 60-0222 (Master Representative Payee File). Additional information regarding this form and our other systems of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10.5 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)**. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant or any member of the claimant's household DIES (SSI eligibility ends with the month in which the claimant dies);
- the claimant's HOUSEHOLD CHANGES (someone moves in/out of the place where the claimant lives);
- the claimant LEAVES THE U.S. (the 50 states, the District of Columbia, and the Northern Mariana Islands) for 30 consecutive days or more;
- the claimant MOVES or otherwise changes the place where he/she actually lives (including adoption, and whereabouts unknown);
- the claimant is ADMITTED TO A HOSPITAL, skilled nursing facility, nursing home, intermediate care facility, or other institution;
- the INCOME of the claimant or anyone in the claimant's household CHANGES (this includes income paid by an organization or employer, as well as monetary benefits from other sources);
- the RESOURCES of the claimant or anyone in the claimant's household CHANGES (this includes when conserved funds reach over $2,000);
- the claimant or anyone in the claimant's household MARRIES;
- the marriage of the claimant or anyone in the claimant's household ends in DIVORCE or ANNULMENT;
- the claimant SEPARATES from his/her spouse;
- the claimant is confined to jail, prison, penal institution or correctional facility;
- the claimant is confined to a public institution by court order in connection WITH A CRIME;
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

IF THE CLAIMANT IS RECEIVING PAYMENTS DUE TO DISABILITY OR BLINDNESS, YOU MUST ALSO REPORT IF:

- the claimant's MEDICAL CONDITION IMPROVES;
- the claimant GOES TO WORK;
- the claimant's VISION IMPROVES, if the claimant is entitled due to blindness;

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

PAYMENT MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail or in person.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed. (Savings are considered resources and may affect the claimant's eligibility to payment.);
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee;
- you will be asked to help in periodically redetermining the claimant's continued eligibility or payment. You will need to keep evidence to help us with the redetermination (e.g., evidence of income and living arrangements).
- you may be required to obtain medical treatment for the claimant's disabling condition if he/she is eligible under the childhood disability provision.

Keep in mind that payments may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

A REMINDER TO PAYEE APPLICANTS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for SSI payments on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you — or someone for you — should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

THE PRIVACY ACT

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We rarely use the information provided on this form for any purpose other than for making representative payee selections. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form (1) to enable a third party or an agency to assist Social Security in evaluating payee applicants' suitability to be named representative payees; (2) to claimants or other individuals when needed to pursue a claim for recovery of misapplied or misused benefits; (3) to comply with Federal laws requiring the disclosure of the information from our records; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is contained in our System of Records Notice 60-0222 (Master Representative Payee File). Additional information regarding this form and our other systems of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

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YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant DIES (special veterans entitlement ends the month after the claimant dies);
- the claimant returns to the United States for a calendar month or longer;
- the claimant moves or changes the place where he/she actually lives;
- the claimant receives a pension, annuity or other recurring payment (includes workers' compensation, veterans benefits or disability benefits), or the amount of the annuity changes;
- the claimant is or has been deported or removed from U.S.;
- the claimant has an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than 1 year;
- YOU have an UNSATISFIED FELONY WARRANT (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You can make your reports by telephone, mail or in person. You can contact any U.S. Embassy, Consulate, Veterans Affairs Regional Office in the Philippines or any U.S. Social Security Office.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed;
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know, as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee.

A REMINDER TO PAYEE APPLICANTS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for Special benefits for WW II Veterans on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits payable, you — or someone for you — should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

THE PRIVACY ACT

Sections 205(a) and 205(j) of the Social Security Act, as amended, authorize us to collect the information on this form. The information you provide will be used to determine if you are qualified to serve as a representative payee. Your response is voluntary. However, failure to provide the requested information will prevent us from making a determination to select you as representative payee.

We rarely use the information provided on this form for any purpose other than for making representative payee selections. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form (1) to enable a third party or an agency to assist Social Security in evaluating payee applicants' suitability to be named representative payees; (2) to claimants or other individuals when needed to pursue a claim for recovery of misapplied or misused benefits; (3) to comply with Federal laws requiring the disclosure of the information from our records; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is contained in our System of Records Notice 60-0222 (Master Representative Payee File). Additional information regarding this form and our other systems of records notices and Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10.5 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

PHYSICIAN'S/MEDICAL OFFICER'S STATEMENT OF PATIENT'S CAPABILITY TO MANAGE BENEFITS

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U. S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** ***Send only comments relating to our time estimate above to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

In replying, use this address:
SOCIAL SECURITY ADMINISTRATION

TELEPHONE NUMBER (Including Area Code)
( ) –

DATE

SSA CONTACT

IDENTIFYING INFORMATION (SSA Only)
If different from patient

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER
– –

Privacy Act Statement

Sections 205(a) and 205(j), of the Social Security Act, as amended, authorize us to collect this information. The information is needed to make a determination regarding whether or not the named individual should be paid benefits directly or whether benefits should be paid to a representative payee. The information you furnish on this form is voluntary. However, failure to provide all or part of the information could prevent an accurate and timely decision on the proper payee for benefit receipt purposes.

We rarely use the information you supply for any purpose other than for making a determination on a claim. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to: (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and (4) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0089 and 60-0222. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER – –	PATIENT'S DATE OF BIRTH	

YOUR HELP IS NEEDED

The patient shown above has filed for or is receiving Social Security or Supplemental Security Income payments. We need you to complete the back of this form and return it to us in the enclosed envelope to help us decide if we should pay this person directly or if he or she needs a representative payee to handle the funds. Please Note: This determination affects how benefits are paid and has no bearing on disability determinations; SSA will NOT pay for this information. Thank you for your help.

WHO IS A REPRESENTATIVE PAYEE

A representative payee is someone who manages the patient's money to make sure the patient's needs are met. The payee has a strong and continuing interest in the patient's well-being and is usually a family member or close friend.

WHO NEEDS A REPRESENTATIVE PAYEE

Some individuals age 18 and older who have mental or physical impairments are not capable of handling their funds or directing others how to handle them to meet their basic needs, so we select a representative payee to receive their payments. Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia. However, even though a person may need some assistance with such things as bill paying, etc., does not necessarily mean he/she cannot make decisions concerning basic needs and is incapable of managing his/her own money.

PLEASE COMPLETE THE INFORMATION ON THE REVERSE OF THIS FORM

PATIENT'S NAME		PATIENT'S ADDRESS (Number and Street, City, State, and ZIP Code)
PATIENT'S SOCIAL SECURITY NUMBER – –	PATIENT'S DATE OF BIRTH	

1. Date you last examined the patient _____

2. Do you believe the patient is capable of managing or directing the management of benefits in his or her own best interest?

   By capable we mean that the patient:

   - Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
   - Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ Yes	☐ No	☐ Unsure
If "Yes", please omit question 3, but be sure to sign and date the form.	If "No", please provide a brief summary of the findings that led to this conclusion. Also, complete question 3.	If "unsure", please explain.

3. Do you expect the patient to be able to manage funds in the future (for example, the patient is temporarily unconscious)?

   ☐ Yes ☐ No

   If yes, please explain.

NAME OF PHYSICIAN/MEDICAL OFFICER (Please print.)	TITLE
ADDRESS (Number and street, City, State, and ZIP Code)	TELEPHONE NUMBER *(Include Area Code)* ( ) –

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF PHYSICIAN/ MEDICAL OFFICER	DATE

Form **SSA-787** (05-2010) ef (05-2010)

DISABILITY REPORT - CHILD - Form SSA-3820-BK
READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM THIS IS NOT AN APPLICATION

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Fill out as much of this form as you can before your interview appointment. Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answers, or the answer is "none" or "does not apply," write: "don't know," or " none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HMO/THERAPIST/ OTHER/ HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use Section 10, "DATE AND REMARKS," on Pages 11 and 12, and show the number of the question being answered.

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records
- Copies of the child's prescriptions or medicine containers
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and medicine containers.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), and 1631 of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to determine if a child is eligibility for benefit payments.

Furnishing us this information is voluntary. However, failing to provide us with the requested information could prevent us from making an accurate and timely decision on your claim.

We rarely use the information you supply for any purpose other than the reason stated above. However, we may use the information for the efficient administration and integrity of our programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability office and Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and private entities under contract with us.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information form these matching programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of records Notice entitled Claims Folder System (60-0089). This notice, additional information regarding this form, information regarding our programs, are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 90 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to***: *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

DISABILITY REPORT - CHILD

SECTION 1 - INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*

B. **CHILD'S SOCIAL SECURITY NUMBER**

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*

YOUR MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*

CITY	STATE	ZIP CODE

YOUR EMAIL ADDRESS (Optional)

D. **YOUR DAYTIME PHONE NUMBER** *(If you do not have a phone number where we can reach you, give us a daytime number where we can leave a message for you.)*

Area Code _____ *Number* _____ ☐ Your Number ☐ Message Number ☐ None

E. What is **your relationship to the child**?

F. Can you **speak and understand English**? ☐ YES ☐ NO

If "NO", what is your preferred language? _____

NOTE: If you cannot speak and understand English, we will provide you an interpreter, free of charge. **If you cannot speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages?

☐ YES (Enter name, address, phone number, relationship) ☐ NO

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City _____ *State* _____ *ZIP* _____ DAYTIME PHONE *Area Code* _____ *Number* _____

Can you **read and understand English**? ☐ YES ☐ NO

G. Does the child live with you? ☐ YES ☐ NO If "NO", with whom does the child live?

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City _____ *State* _____ *ZIP* _____ DAYTIME PHONE *Area Code* _____ *Number* _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

Disability Report - Child - Form SSA-3820-BK

SECTION 1 - INFORMATION ABOUT THE CHILD

H. Can the child speak and understand English? ☐ YES ☐ NO

If "NO," what languages can the child speak? _____

If the child understands any other languages, list them here: _____

I. What is the child's height *(without shoes)*? _____

What is the child's weight *(without shoes)*? _____

J. Does the child have a **medical assistance** card? (for example Medicaid, Medi-Cal) ☐ YES ☐ NO

If "YES", show the **number** here: _____

SECTION 2 - CONTACT INFORMATION

A. Does the child have a legal guardian or custodian other than you?

☐ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

RELATIONSHIP TO CHILD _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

B. Is there another adult who helps care for the child and can help us get information about the child if necessary?

☐ YES *(Enter name, address, phone number, relationship)* ☐ NO

NAME OF CONTACT _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____

Area Code *Number*

RELATIONSHIP TO CHILD _____

Can this person **speak and understand English**? ☐ YES ☐ NO

If "NO", what is this person's preferred language? _____

Can this person **read and understand English**? ☐ YES ☐ NO

SECTION 3 - THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**?

B. When did the child become disabled? _____
Month *Day* *Year*

C. Do the child's illnesses, injuries or conditions cause **pain** or other symptoms? ☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

☐ YES ☐ NO

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST/OTHER**. Include the child's **next appointment**.

1. **NAME**

			DATES
STREET ADDRESS			**FIRST VISIT**
CITY	**STATE**	**ZIP**	**LAST VISIT**
PHONE _____ _____ *Area Code* *Number*	**Patient ID #** (If known)		**NEXT APPOINTMENT**

REASONS FOR VISITS

WHAT **TREATMENT** WAS RECEIVED?

2. **NAME**

			DATES
STREET ADDRESS			**FIRST VISIT**
CITY	**STATE**	**ZIP**	**LAST VISIT**
PHONE _____ _____ *Area Code* *Number*	**Patient ID #** (If known)		**NEXT APPOINTMENT**

REASONS FOR VISITS

WHAT **TREATMENT** WAS RECEIVED?

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3. **NAME**			**DATES**
STREET ADDRESS			**FIRST VISIT**
CITY	**STATE**	**ZIP**	**LAST VISIT**
PHONE _____ _____ *Area Code* *Number*	**Patient ID #** (If known)		**NEXT APPOINTMENT**

REASONS FOR VISITS

WHAT **TREATMENT** WAS RECEIVED?

If you need more space, use Section 10.

D. List each **HOSPITAL/CLINIC.** Include the child's **next appointment.**

1. HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
NAME	☐ **INPATIENT STAYS** *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS	☐ **OUTPATIENT VISITS** *(Sent home same day)*		
CITY _____ **STATE** _____ **ZIP** _____ **PHONE** _____ _____ *Area Code* *Number*	☐ **EMERGENCY ROOM VISITS**	**DATE FIRST VISIT**	**DATE LAST VISIT**
		DATES OF VISITS	

Next **appointment**	The child's hospital/clinic **number**

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

SECTION 4 - INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
NAME	☐ **INPATIENT STAYS** *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS	☐ **OUTPATIENT VISITS** *(Sent home same day)*		
CITY _____ **STATE** _____ **ZIP** _____ **PHONE** _____ *Area Code* _____ *Number*	☐ **EMERGENCY ROOM VISITS**	**DATE FIRST VISIT**	**DATE LAST VISIT**
		DATES OF VISITS	

Next **appointment**	The child's hospital/clinic **number**

Reasons for visits

What **treatment** did the child receive?

What **doctors** does the child see at this hospital/clinic on a regular basis?

If you need more space, use Section 10.

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies, and/or Worker's Compensation), or is the child scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME			**DATES**
ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE _____ *Area Code* _____ *Number*			NEXT APPOINTMENT

CLAIM NUMBER *(If any)*

REASONS FOR VISITS

If you need more space, use Section 10.

SECTION 5 - MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions? ☐ YES ☐ NO

If "YES", tell us the following: *(Look at the child's medicine containers, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

If you need more space, use Section 10.

SECTION 6 - TESTS

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions?

☐ YES ☐ NO If "YES", tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN WAS/WILL TESTS BE DONE? *(Month, day, year)*	WHERE DONE *(Name of Facility)*	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY - Name of body part _____			
SPEECH/LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY - Name of body part _____			
MRI/CAT SCAN - Name of body part _____			

If the child has had other tests, list them in Section 10.

SECTION 7 - ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

Headstart (Title V)	☐ YES	☐ NO
Public or Community Health Department	☐ YES	☐ NO
Child Welfare or Social Service Agency or WIC	☐ YES	☐ NO
Early Intervention Services	☐ YES	☐ NO
Program for Children with Special Health Care Needs	☐ YES	☐ NO
Mental Health/Mental Retardation Center	☐ YES	☐ NO

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work?

☐ YES ☐ NO

If you answered "YES" to any of the above in A. or B., please complete C. below:

C. 1. NAME OF AGENCY

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

TYPE OF TEST	WHEN DONE
TYPE OF TEST	WHEN DONE

FILE OR RECORD NUMBER

2. NAME OF AGENCY

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

TYPE OF TEST	WHEN DONE
TYPE OF TEST	WHEN DONE

FILE OR RECORD NUMBER

If there are any other agencies, show them in Section 10.

SECTION 8 - EDUCATION

A. Is the child currently enrolled in any school? ☐ YES, grade: _____ ☐ NO, too young

☐ NO, other reason (complete B)

B. Other reason the child is not enrolled in school:

_____

_____

_____

_____

_____

_____

_____

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *County* *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? ☐ YES ☐ NO

If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech/language therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST _____

SECTION 8 - EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *County* *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? ☐ YES ☐ NO
If "YES", complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in special education? ☐ YES ☐ NO
If "YES", and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech/language therapy? ☐ YES ☐ NO

If "YES", and different from above, give:

NAME OF SPEECH/LANGUAGE THERAPIST _____

If there are other schools, show them in Section 10.

E. Is the child attending Daycare/Preschool? ☐ YES ☐ NO

If "YES", complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *County* *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

SECTION 9 - WORK HISTORY

A. Has the child ever worked (including sheltered work)? ☐ YES ☐ NO

If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____

City *State* *ZIP*

PHONE NUMBER _____ _____

Area Code *Number*

NAME OF SUPERVISOR _____

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 - DATE AND REMARKS

Please give the date you filled out this disability report.

_____

Date (MM/DD/YYYY)

Use this section for any additional information about your child.

SECTION 10 - REMARKS

QUESTIONNAIRE FOR CHILDREN CLAIMING SSI BENEFITS

Please print, type, or write clearly and answer all items to the best of your ability. If you need help completing any part of this form, we will help you. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. If you do not know the answer, enter "unknown." If the question does not apply, enter "N/A." If you need more space to answer any of the questions, please use "REMARKS" and enter the number of the question next to your answer.

Child's Full Name	Social Security Number	Date (month, day, year)

Informant's Name	Relationship to Child	Daytime Telephone Number (including Area Code)

1. Is (was) the child cared for by a baby sitter? Does (did) the child attend any type of preschool, daycare and/or after school program? If so, please specify. If more than one of the above, use the "REMARKS" section.

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	Dates Attended

2. a. Is (was) the child in school? ☐ Yes ☐ No

If "***yes***," and the school was not listed in Item 12A of the SSA-3820-F6, please show it here.
(If more than one, use the "REMARKS" section.)

Name	Address (Number, Street, City, State, ZIP Code)
Telephone Number (including Area Code)	Dates Attended
Grade Level Completed	Last Teacher's Name

2.b. Is the child in a special education program?	☐ Yes ☐ No ☐ Don't Know
c. Does the school make any special accommodations for the child; e.g., adaptive furniture, wheelchair ramps, extra assistance or attention?	☐ Yes ☐ No ☐ Don't Know
If **"yes"** in 2.b. or 2.c., indicate type of program and/or accommodations:	Specify number of hours per week the child is in special education program:
d. Do you have a copy of the child's individual education plan (IEP), the report in which the teacher outlines the child's problems and lists the plans for correcting them? If "***yes***," please provide a copy.	☐ Yes ☐ No
3. Does the child receive any special counseling or tutoring?	
a. In school	☐ Yes ☐ No
b. Outside school	☐ Yes ☐ No

If "***yes***," in 3.a. or 3.b., please indicate: *(If more than one, use the "REMARKS" section.)*

Type of Counseling, Tutoring	
Date Began and Ended (If completed)	Frequency of Visits
Counselor's or Tutor's Name	Telephone Number (including Area Code)
Address (Number, Street, City, State, ZIP Code)	

4. Does the child or family have a child welfare, social services or early intervention caseworker?	☐ Yes ☐ No

If "***yes***," please provide the following information: *(If more than one, use the "REMARKS" section.)*

Caseworker's Name	Organization
Address (Number, Street, City, State, ZIP Code)	Telephone Number (including Area Code)
File or Record Number	Date First Saw/Last Saw Caseworker

5. Has the child ever been tested or evaluated by any of the following agencies or organizations? If "***yes***," indicate in the space provided below the agency name, address, telephone number, record number, and the type and date of test or evaluation performed *(e.g., vision, hearing, speech, physical).*

a. Public/Community Health Department	☐ Yes	☐ No
b. Child Welfare/Social Services Agency	☐ Yes	☐ No
c. Developmental Evaluation Center	☐ Yes	☐ No
d. Mental Health/Intellectual Disability	☐ Yes	☐ No
e. Special Needs/Crippled Children Agency	☐ Yes	☐ No
f. Speech and Hearing Center	☐ Yes	☐ No
g. Women, Infants and Children (WIC) Program	☐ Yes	☐ No

Use the letter designation *(5a, 5b, etc.)* to identify the agency.

If additional space is needed, use "REMARKS" section.

6. Does (did) the child receive any special therapy (physical, speech and language, occupational), exercises, or any other services for his/her impairments?	☐ Yes ☐ No
Include information about any therapy or exercises the parent, guardian or caregiver provides the child.	

If **"yes,"** indicate below the therapist's name, the name of the person who PRESCRIBED AND/OR DESIGNED the therapy program, the type(s) and frequency of treatment, when treatment began and ended (if completed), and where treatment was received *(e.g., home, hospital, therapist's office, clinic.)*

Therapist's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

Therapist's Name	Telephone No. (including Area Code)

Address (Number, Street, City, State, ZIP Code)

Person Who Prescribed/Designed Therapy

Information about Therapy:

7. Does (did) the child receive vocational rehabilitation services? If "***yes***," describe services received below the rehabilitation counselor's information. Include dates and record number.	☐ Yes ☐ No
Rehabilitation Counselor's Name	Telephone No. (including Area Code)
Address (Number, Street, City, State, ZIP Code)	
Services received:	

(If additional space is needed, use "REMARKS" section.)

NOTE: PROVIDING INFORMATION ABOUT THE CHILD'S INVOLVEMENT WITH THE COURT SYSTEM IS OPTIONAL

8. Has the child ever been involved with the court system other than in custody proceedings? If "***yes***," please explain involvement, including testing and evaluation.	☐ Yes ☐ No
Youth Development Center's Name	
Address (Number, Street, City, State, ZIP Code)	
Probation or Parole Officer's Name	Telephone No. (including Area Code)
Address (Number, Street, City, State, ZIP Code)	
Involvement including any testing and evaluation:	

9. Does (did) the child participate in any community or school activities, such as choir, Special Olympics, Boy's/Girl's Club, Scouts, or sports? ☐ Yes ☐ No

If "yes," describe involvement, amount of time spent in activity, and level of participation. Provide name, address, and telephone number of individual who supervises the activity. Include dates of involvement. If involvement ended, explain why.

10. If the child takes any medication on an ongoing basis, please indicate the following:

MEDICATION DOSAGE/ FREQUENCY	PRESCRIBED BY (NAME)	REASON FOR MEDICATION	DESCRIBE ANY SIDE EFFECTS

How well does the medication(s) work? Please explain:

11 a. If you are unable to give us information we need about the child, is there someone else who helps care for the child and, knows of the child's impairment who can help us get the information we need, and, if necessary, bring the child to a consultative examination?

☐ Yes ☐ No

b. If "yes," please provide the following information about this person

Name

Address (Number, Street, City, State, ZIP Code)

Daytime telephone number (including Area Code)

Relationship *(e.g., relative, neighbor, family friend)* to the child?

REMARKS:

REMARKS (continued):

Privacy Act Statement
Questionnaire for Children Claiming SSI Benefits

Sections 223 and 1632 of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on your claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than for the reasons explained above. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs);

2. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System (60-0089); Supplemental Security Income Record and Special Veterans Benefits (60-0103); and Electronic Disability (eDIB) Claim File (60-0320). Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

REQUEST FOR RECONSIDERATION

(Do not write in this space)

NAME OF CLAIMANT		NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant.)*
CLAIMANT SSN – –	CLAIMANT CLAIM NUMBER (if different from SSN) – –	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER – –
SPOUSE'S NAME *(Complete ONLY in SSI cases)*		SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)* – –

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital /medical, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See the three ways to appeal in the How To Appeal Your Supplemental Security Income (SSI) Or Special Veterans Benefit (SVB) Decision instructions.)

"I want to appeal your decision about my claim for Supplemental Security Income (SSI) or Special Veterans Benefits (SVB). I've read about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

ENTER ADDRESSES FOR THE CLAIMANT AND THE REPRESENTATIVE

CLAIMANT SIGNATURE- OPTIONAL			NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY		
MAILING ADDRESS			MAILING ADDRESS		
CITY	STATE	ZIP CODE –	CITY	STATE	ZIP CODE –
TELEPHONE NUMBER *(Include area code)* ( ) –		DATE	TELEPHONE NUMBER *(Include area code)* ( ) –		DATE

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

See list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO
2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO
3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
   (If "NO", attach claimant's explanation for delay and attach any pertinent letter, material, or information in Social Security office.)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.300)

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS

ROUTING INSTRUCTIONS (CHECK ONE) →

☐ DISABILITY DETERMINATION SERVICES *(ROUTE WITH DISABILITY FOLDER)*

☐ ODO, BALTIMORE

☐ PROGRAM SERVICE CENTER

☐ OIO, BALTIMORE

☐ OEO, BALTIMORE

☐ DISTRICT OFFICE RECONSIDERATION

☐ CENTRAL PROCESSING SITE (SVB)

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records.

ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS
(See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title II

1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

Title XVI

1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)

1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II--items 3, 4, 10, 11 & 16.

Title XVIII

1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.

REQUEST FOR RECONSIDERATION

(Do not write in this space)

NAME OF CLAIMANT		NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(If different from claimant.)*
CLAIMANT SSN – –	CLAIMANT CLAIM NUMBER (if different from SSN) – –	SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER – –
SPOUSE'S NAME *(Complete ONLY in SSI cases)*		SPOUSE'S SOCIAL SECURITY NUMBER *(Complete ONLY in SSI cases)* – –

CLAIM FOR *(Specify type, e.g., retirement, disability, hospital/medical, SSI, SVB, etc.)*

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY

(See the three ways to appeal in the How To Appeal Your Supplemental Security Income (SSI) Or Special Veterans Benefit (SVB) Decision instructions.)

"I want to appeal your decision about my claim for Supplemental Security Income (SSI) or Special Veterans Benefits (SVB). I've read about the three ways to appeal. I've checked the box below."

☐ Case Review ☐ Informal Conference ☐ Formal Conference

ENTER ADDRESSES FOR THE CLAIMANT AND THE REPRESENTATIVE

CLAIMANT SIGNATURE- OPTIONAL			NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY		
MAILING ADDRESS			MAILING ADDRESS		
CITY	STATE	ZIP CODE –	CITY	STATE	ZIP CODE –
TELEPHONE NUMBER *(Include area code)* ( ) –		DATE	TELEPHONE NUMBER *(Include area code)* ( ) –		DATE

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

See list of initial determinations

1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO
2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO
3. IS THIS REQUEST FILED TIMELY? ☐ YES ☐ NO
   (If "NO", attach claimant's explanation for delay and attach any pertinent letter, material, or information in Social Security office.)

RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)

☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.300)

☐ REQUIRED DEVELOPMENT ATTACHED

☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

SOCIAL SECURITY OFFICE ADDRESS

ROUTING INSTRUCTIONS (CHECK ONE) →

☐ DISABILITY DETERMINATION SERVICES *(ROUTE WITH DISABILITY FOLDER)*

☐ ODO, BALTIMORE

☐ PROGRAM SERVICE CENTER

☐ OIO, BALTIMORE

☐ OEO, BALTIMORE

☐ DISTRICT OFFICE RECONSIDERATION

☐ CENTRAL PROCESSING SITE (SVB)

NOTE: Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records.

HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

There are three different ways to appeal. You can pick the appeal that fits your case. You can have a lawyer, friend, or someone else help you with your appeal.

Here are the three ways to appeal:

1. CASE REVIEW:

You can give us more facts to add to your file. Then we'll decide your case again. You don't meet with the person who decides your case.

You can pick this kind of appeal in all cases.

2. INFORMAL CONFERENCE:

You'll meet with the person who will decide your case. You can tell that person why you think you're right. You can give us more facts to help prove you're right. You can bring other people to help explain your case.

You can pick this kind of appeal in all SSI cases *except* two. You can't have it if we turned down your SSI application for medical reasons or because you're not blind. Also you can't have it if we're giving you SSI but you disagree with the date we said you became blind or disabled. In SVB cases, you can pick this kind of appeal only if we're stopping or lowering your SVB payment.

3. FORMAL CONFERENCE:

This is a meeting like an informal conference. Plus, we can make people come to help prove you're right. We can do this even if they don't want to help you. You can question these people at your meeting.

You can pick this kind of appeal only if we're stopping or lowering your SSI or SVB payment. You can't get it in any other case.

Now you know the three kinds of appeals. You can pick the one that fits your case. Then fill out this form. We'll help you fill it out.

There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789-U4) FOR YOUR APPEAL.

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

Privacy Act Statement
Collection and Use of Personal Information

Section 205(a), of the Social Security Act as amended, [42 U.S.C. 405(a)] and Title 20 C.F.R. 404.907 - 404.922 and 416.1407–416.1422 authorize us to collect this information. We will use this information to help us determine your entitlement to benefits. Providing this information is voluntary. However, failing to procide us with all or part of the requested information may affect our ability to re-evaluate the decision on your claim.

We rarely use the information you provide on this form for any purpose other than for determining problems in Social Security programs. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. Information from these matching agencies can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notice entitled Claims Folder System 60-0089, and 60-0103, Supplemental Security Income Record and Special Veterans Benefits. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at any local Social Security office.

Paperwork Reduction Act Statement / This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to : SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0349

REQUEST FOR RECONSIDERATION -
DISABILITY CESSATION - RIGHT TO APPEAR
(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY
(DO NOT WRITE IN THIS SPACE)

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from Claimant)	SOCIAL SECURITY NUMBER
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

☐ FO Code _____
☐ Benefit Continuation
☐ Foreign Language Notice _____

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION. My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):
NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (If "NONE" write "NONE") (Attach additional page if needed):

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY **OR** CHECK BLOCK 2.

☐ 1. I (and/or my representative) wish to appear at a face-to-face disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.

☐ I need an interpreter at the disability hearing - Language _____
(If you need an interpreter, SSA will provide one at no cost to you.)

OR

☐ 2. I do not wish to appear nor do I wish a representative to appear for me at the disability hearing. I have been advised of my right to have a disability hearing. I understand that a disability hearing will give me a chance to present witnesses. It will also let me explain to the disability hearing officer why my disability benefits should not end. I understand that this chance to be seen and heard could help the disability hearing officer learn about the facts in my case. The disability hearing officer would give me a chance to have people who know about my condition give information and explain how my condition keeps me from working and restricts my activities. I have been told about my right to representation at the disability hearing, including representation by an attorney or other person of my choice. Although the above has been explained to me, I do not want to appear at a disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence in my file, plus any evidence that I submit or that may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a disability hearing prior to the writing of a decision in my case. In this case, I can make the request with any Social Security office.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE		
STREET ADDRESS.			REPRESENTATIVE'S ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	DATE		TELEPHONE NUMBER	DATE	

Witnesses are required ONLY if this form has been signed by mark (X). If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

PRIVACY ACT AND PAPERWORK REDUCTION ACT NOTICE

Sections 205(a), 1631(c)(1)(A) and (B), of the Social Security Act, as amended, authorize us to collect the information on this form. We will use this information to determine your potential eligibility for benefit payments and to help us decide if we need additional information.
Furnishing us this information is voluntary. However, failure to provide us with all or part of the requested information may affect our ability to re-evaluate the decision on your claim.
We rarely use the information you provide for any purpose other than for determining entitlement to benefit payments. However, we may use the information you give us for the administration and integrity of our programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to, the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

2. To comply with federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment or incorrect payments or delinquent debts under these programs.

A complete use of routine uses for this information is available in our Privacy Act Systems of Records Notices, 60-0009, Hearings and Appeals Case Control System, 60-0010, Hearing Office Tracking System of Claimant Cases, and 60-0089, Claims Folders Systems. These notices, additional information regarding our programs and systems, are available online at www.socialsecurity.gov or at any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213 (TTY 1-800-325-0778).** Send **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0349

REQUEST FOR RECONSIDERATION -
DISABILITY CESSATION - RIGHT TO APPEAR
(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY
(DO NOT WRITE IN THIS SPACE)

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from Claimant)	SOCIAL SECURITY NUMBER
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

☐ FO Code _____
☐ Benefit Continuation
☐ Foreign Language Notice _____

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

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NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (If "NONE" write "NONE") (Attach additional page if needed):

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY **OR** CHECK BLOCK 2.

☐ 1. I (and/or my representative) wish to appear at a face-to-face disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.

☐ I need an interpreter at the disability hearing - Language _____
(If you need an interpreter, SSA will provide one at no cost to you.)

OR

☐ 2. I do not wish to appear nor do I wish a representative to appear for me at the disability hearing. I have been advised of my right to have a disability hearing. I understand that a disability hearing will give me a chance to present witnesses. It will also let me explain to the disability hearing officer why my disability benefits should not end. I understand that this chance to be seen and heard could help the disability hearing officer learn about the facts in my case. The disability hearing officer would give me a chance to have people who know about my condition give information and explain how my condition keeps me from working and restricts my activities. I have been told about my right to representation at the disability hearing, including representation by an attorney or other person of my choice. Although the above has been explained to me, I do not want to appear at a disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence in my file, plus any evidence that I submit or that may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a disability hearing prior to the writing of a decision in my case. In this case, I can make the request with any Social Security office.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE		
STREET ADDRESS.			REPRESENTATIVE'S ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	DATE		TELEPHONE NUMBER	DATE	

Witnesses are required ONLY if this form has been signed by mark (X). If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)	ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

PRIVACY ACT AND PAPERWORK REDUCTION ACT NOTICE

Sections 205(a), 1631(c)(1)(A) and (B), of the Social Security Act, as amended, authorize us to collect the information on this form. We will use this information to determine your potential eligibility for benefit payments and to help us decide if we need additional information.
Furnishing us this information is voluntary. However, failure to provide us with all or part of the requested information may affect our ability to re-evaluate the decision on your claim.
We rarely use the information you provide for any purpose other than for determining entitlement to benefit payments. However, we may use the information you give us for the administration and integrity of our programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include, but are not limited to, the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

2. To comply with federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and the Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment or incorrect payments or delinquent debts under these programs.

A complete use of routine uses for this information is available in our Privacy Act Systems of Records Notices, 60-0009, Hearings and Appeals Case Control System, 60-0010, Hearing Office Tracking System of Claimant Cases, and 60-0089, Claims Folders Systems. These notices, additional information regarding our programs and systems, are available online at www.socialsecurity.gov or at any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. To find the nearest office, call 1-800-772-1213 (TTY 1-800-325-0778).** Send **only** comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0349

REQUEST FOR RECONSIDERATION -
DISABILITY CESSATION - RIGHT TO APPEAR
(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY
(DO NOT WRITE IN THIS SPACE)

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from Claimant)	SOCIAL SECURITY NUMBER
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

☐ FO Code _____
☐ Benefit Continuation
☐ Foreign Language Notice _____

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION. My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):
NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (If "NONE" write "NONE") (Attach additional page if needed):

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY **OR** CHECK BLOCK 2.

☐ 1. I (and/or my representative) wish to appear at a face-to-face disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.

☐ I need an interpreter at the disability hearing - Language _____
(If you need an interpreter, SSA will provide one at no cost to you.)

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SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0349

REQUEST FOR RECONSIDERATION -
DISABILITY CESSATION - RIGHT TO APPEAR
(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY
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SSA BENEFIT ELIGIBILITY CHART

RELATIONSHIP OF INDIVIDUAL TO INSURED WORKER	CATEGORY OF BENEFIT		
	RETIREMENT	DISABILITY	SURVIVOR
Worker	X	X	
Spouse over 62 years old (Note 1)	X	X	
Spouse under 62 years old who is caring for a child who is under 16 or a disabled child and receiving checks on the worker's record	X	X	
Widow or widower who is 60 years or over (Notes 1 and 2)			X
Widow or widower of any age who is caring for a child who is under 16 or a disabled child and receiving checks on the worker's record (Notes 1 & 2)			X
Disabled widow or widower of a worker who is 50 years or over and whose disability started before the worker's death or within seven years of death of the worker's death (Notes 1 & 2)		X	X
Unmarried child, adopted child, and sometimes step-child or grandchild - Under 18 years or under 19 years if in high school full-time	X		X
Unmarried child 18 or over if he or she has a disability that started before age 22 (these children must meet the adult definition of disability)		X	X
Married child who is the recipient of a Social Security benefit on a parent's work record who marries another Social Security recipient	X	X	X
Divorced widow or widower who is at least 60 years old **and** married to the worker for at least 10 years (Notes 1 & 2)			X
Divorced widow or widower who is at least 50 years old **and** disabled **and** married to the worker for at least 10 years **and** whose disability began either before the worker's death or within seven years of the worker's death (Notes 1 & 2)		X	X
Divorced widow or widower of any age caring for a child under 16 or disabled who is eligible for Social Security benefits (Notes 1 & 2)			X

1 – Not eligible for an equal or higher benefit on his or her own work record
2 – Not currently married unless the remarriage occurred after age 60 or age 50 if disabled

DISABILITY REPORT - ADULT
SSA-3368-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The information you give us on this report will be used by the office that makes the disability decision on your disability claim. Completing this report accurately and completely will help us expedite your claim. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please do **not** ask your health care provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you. If we ask you to do so, please mail the completed report to us ahead of time.

Note: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION,** unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any question, please use Section 11 - Remarks on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any of your medical records, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and the completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or is expected to result in death. So when we ask "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

Privacy Act Statement
Collection and Use of Personal Information

Section 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on the named claimant's claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on the named claimant's claim.

We rarely use the information you supply for any purpose other than to make decisions regarding claims. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Records Notice entitled, Claims Folders Systems, 60-0089. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

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SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only- Do not write in this box.

Related SSN _____

Number Holder _____

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle Initial, Last)

1.B. Social Security Number

1.C. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

1.D. Email Address

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.

Phone number _____

☐ Check this box if you do not have a phone or a number where we can leave a message .

1.F. Alternate Phone Number - another number where we may reach you, if any.

Alternate phone number _____

1.G. Can you speak and understand English? ☐ YES ☐ NO

If no, what language do you prefer? _____

If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? ☐ YES ☐ NO

1.I. Can you write more than your name in English? ☐ YES ☐ NO

1.J. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname. ☐ YES ☐ NO

If yes, please list them here:

SECTION 2 - CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last)

2.B. Relationship to you

2.C. Daytime Phone Number (as described in 1.E. above)

_____

2.D. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

2. E. Can this person speak and understand English? ☐ YES ☐ NO

If no, what language is preferred? _____

SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?

- ☐ The person who is applying for disability. (Go to Section 3 - Medical Conditions)
- ☐ The person listed in 2.A. (Go to Section 3 - Medical Conditions)
- ☐ Someone else (Complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last)	**2.H.** Relationship to Person Applying

2.I. Daytime Phone Number _____

2.J. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

SECTION 3 - MEDICAL CONDITIONS

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1.
2.
3.
4.
5.

If you need more space, go to Section 11-Remarks on the last page

3.B. What is your height without shoes? ____ feet ____ inches OR ____ centimeters (if outside USA)

3.C. What is your weight without shoes? ____ pounds OR ____ kilograms (if outside USA)

3.D. Do your conditions cause you pain or other symptoms? ☐ YES ☐ NO

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

- ☐ No, I have never worked (Go to question **4.B.** below)
- ☐ No, I have stopped working (Go to question **4.C.** below)
- ☐ Yes, I am currently working (Go to question **4.F.** on page 3)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year) _____ (Go to Section 5 on page 3)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year) _____

Why did you stop working?

- ☐ Because of my condition(s).
- ☐ Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed) _____

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working? (month/day/year) _____

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours, or rate of pay)

- ☐ No (Go to Section 5 - Education and Training on page 3)
- ☐ Yes When did you make changes? (month/day/year) _____

SECTION 4 - WORK ACTIVITY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than $1,010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No (Go to Section 5) ☐ Yes (Go to Section 5)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

☐ No When did your condition(s) first start bothering you? (month/day/year) _____

☐ Yes When did you make changes? (month/day/year) _____

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1,010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ NO ☐ YES

SECTION 5 - EDUCATION AND TRAINING

5.A. Check the highest grade of school completed. College:

0	1	2	3	4	5	6	7	8	9	10	11	12	GED	1	2	3	4 or more
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Date completed: _____

5.B. Did you attend special education classes? ☐ YES ☐ NO (Go to 5.C.)

Name of School _____

City _____ State/Province _____ Country (If not USA) _____

Dates attended special education classes: from _____ to _____

5.C. Have you completed any type of specialized job training, trade, or vocational school?

☐ YES ☐ NO

If "Yes," what type? _____ Date completed: _____

If you need to list other education or training use Section 11 - Remarks on the last page.

SECTION 6 - JOB HISTORY

6.A. List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

☐ Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate of Pay	
		From MM/YY	To MM/YY			Amount	Frequency
1.							
2.							
3.							
4.							
5.							

SECTION 6 - JOB HISTORY (continued)

Check the box below that applies to you.

☐ I had **only one job** in the last 15 years before I became unable to work. Answer the questions below.

☐ I had **more than one job** in the last 15 years before I became unable to work. Do **not** answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day? _____

_____

_____

(If you need more space, use Section 11 - Remarks on the last page.)

6.C. In this job, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform any duties like this? ☐ YES ☐ NO

6.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk		Stoop *(Bend down & forward at waist.)*		Handle large objects	
Stand		Kneel *(Bend legs to rest on knees.)*		Write, type, or handle small objects	
Sit		Crouch *(Bend legs & back down & forward.)*		Reach	
Climb		Crawl *(Move on hands & knees.)*			

6.E. Lifting and carrying *(Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job.)* _____

_____

_____

_____

6.F. Check **heaviest** weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

6.G. Check weight **frequently** lifted: *(by frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

6.H. Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (if No, go to **6.I.**)

How many people did you supervise? _____

What part of your time did you spend supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

6.I. Were you a lead worker? ☐ YES ☐ NO

SECTION 7 - MEDICINES

7. Are you taking any medicines (prescription or non-prescription)?

☐ YES (Give the information requested below. You may need to look at your medicine containers.)

☐ NO (GotoSection8-MedicalTreatment.)

Name of Medicine	If prescribed, give name of doctor	Reason for medicine

If you need to list other medicines, go to Section 11 - Remarks on the last page.

SECTION 8 - MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

8.A. For any **physical** condition(s)?

☐ YES ☐ NO

8.B. For any **mental** condition(s) **(including emotional or learning problems)**?

☐ YES ☐ NO

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
First Visit _____	A. _____	A. Date in _____ Date out _____
Last Visit _____	B. _____	B. Date in _____ Date out _____
Next scheduled appointment (if any) _____	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests,use Section 11-Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.D. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
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Next scheduled appointment (if any) _____	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

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☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.E. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
First Visit _____	A. _____	A. Date in _____ Date out _____
Last Visit _____	B. _____	B. Date in _____ Date out _____
Next scheduled appointment (if any) _____	C. _____	C. Date in _____ Date out _____

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What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

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☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.F. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
First Visit _____	A. _____	A. Date in _____ Date out _____
Last Visit _____	B. _____	B. Date in _____ Date out _____
Next scheduled appointment (if any) _____	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
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☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.G. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits**	**3. Overnight hospital stays**
First Visit _____	List the most recent date first	List the most recent date first
Last Visit _____	A. _____	A . Date in _____ Date out _____
Next scheduled appointment (if any) _____	B. _____	B. Date in _____ Date out _____
	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you have been treated by more than five doctors or hospitals, use Section 11 - Remarks on the last page and give the same detailed information as above for each healthcare provider.

SECTION 9 - OTHER MEDICAL INFORMATION

9. Does **anyone else** have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

☐ YES (Please complete the information below.)

☐ NO (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11 on the last page.)

Name of Organization	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Name of Contact Person	Claim or ID number (if any)

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.
SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

10.A. Have you participated, or are you participating in:

- An individual work plan with n employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An Individualized Education Program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the following information) ☐ NO (Go to Section 11)

10.B. Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

10.C. When did you start participating in the plan or program? _____

SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES (continued)

10.D. Are you still participating in the plan or program?

☐ YES, I am scheduled to complete the plan or program on: _____

☐ **NO.** I completed the plan or program on: _____

☐ **NO.** I stopped participating in the plan or program before completing it because:

_____

_____

_____

10.E. List the types of services, tests, or evaluations that you received (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes).

_____

_____

_____

If you need to list another plan or program use Section 11 - Remarks and give the same detailed information as above.

SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

_____

_____

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Date Report Completed	___ / ___ / ___ month, day, year

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
SSN - -	Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange)**:**
OF WHAT *All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including* , and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign
☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP -

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	**IF** needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory **or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

MEDICAL AND JOB WORKSHEET - ADULT

Please do **not** mail this worksheet to your local office.
Did you know that you can start the application process online?
Visit ***www.socialsecurity.gov/applyfordisability*** for more information!
Complete this worksheet to get ready for the appointment or when filing online. This worksheet is not the application for Social Security disability benefits. You should bring this worksheet to your appointment or have it with you if your appointment is by telephone.

A. Medical Conditions

List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

	CONDITIONS
1.	
2.	
3.	
4.	
5.	

B. If you are not working, when did you stop working?

C. Height without shoes:_____feet_____inches **Weight without shoes:** _____ pounds

D. Medical Sources

Please list any doctors, hospitals, clinics, therapists, or emergency rooms you have visited because of your conditions.

NAME	ADDRESS	PHONE NUMBER (with area code)	DATE FIRST SEEN OR ADMISSION DATE	DATE LAST SEEN OR DISCHARGE DATE

E. Medicines

Please list any medicines you take and why you take them. If prescribed, please provide the doctor's name.

NAME OF MEDICINE	WHY YOU TAKE IT	PRESCRIBED BY

F. Medical Tests

Please list any medical tests you had or are going to have in the future.

NAME OF TEST	PROVIDER WHO SENT YOU	DATE(S)

G. Job History

List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

JOB TITLE (*e.g., cook*)	TYPE OF BUSINESS (*e.g., restaurant*)	DATES WORKED		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY	
		FROM Mo/Yr	TO Mo/Yr			Amount	Frequency

Bring this worksheet to your appointment or have it with you if your appointment is by telephone. Do not delay filing your application, even if you do not have all of the information. We will help you get any missing information.

Checklist – Adult Disability Interview

We encourage you to begin the application process online.

Visit ***www.socialsecurity.gov/applyfordisability*** to get started!

Use this **Checklist** to get ready for your appointment or when filing online. We need your personal and income information to complete the interview to determine if you are eligible for disability benefits. Keep your appointment even if you do not have all of the information. We will help you get any missing information.

☑ **Check off the applicable items below as you get them together for your interview.**

- ❑ **Medical records already in your possession.** (We will help you get the rest of your medical records. Please bring whatever medical records you have to the interview).
- ❑ Workers' compensation information, including the settlement agreement, date of injury, claim number, and proof of other disability awarded payment amounts.
- ❑ Names and dates of birth of your minor children and your spouse.
- ❑ Dates of marriages and divorces.
- ❑ Checking or savings account number, including the bank's 9-digit routing number, if you want Direct Deposit for your benefit checks.
- ❑ Name, address, and phone number of a person we can contact if we are unable to get in touch with you.
- ❑ If a medical release Form SSA-827 (Authorization to Disclose Information to the Social Security Administration) was included with this package, please **complete** (sign and date with witness signature) **and** return it as directed.
- ❑ If unable to file online, **complete** the "Medical and Job Worksheet – Adult" and **bring** to your interview.

Bring the Checklist items and information to your appointment or have them with you if your appointment is by telephone.

Do not delay filing your application, even if you do not have all of the information.

2014 Medicare Costs

Medicare Part A (Hospital Insurance) Costs

Part A Monthly Premium

Most people don't pay a Part A premium because they paid Medicare taxes while working. If you don't get premium-free Part A, you pay up to $426 each month.

Hospital Stay

In 2014, you pay

- $1,216 deductible per benefit period
- $0 for the first 60 days of each benefit period
- $304 per day for days 61–90 of each benefit period
- $608 per "lifetime reserve day" after day 90 of each benefit period (up to a maximum of 60 days over your lifetime)

Skilled Nursing Facility Stay

In 2014, you pay

- $0 for the first 20 days of each benefit period
- $152 per day for days 21–100 of each benefit period
- All costs for each day after day 100 of the benefit period

Medicare Part B (Medical Insurance) Costs

Part B Monthly Premium

You pay a Part B premium each month. Most people will pay the standard premium amount. However, if your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you may pay more.

If your yearly income in 2012 was			You pay (in 2014)
File individual tax return	File joint tax return	File married & separate tax return	
$85,000 or less	$170,000 or less	$85,000 or less	$104.90
above $85,000 up to $107,000	above $170,000 up to $214,000	N/A	$146.90
above $107,000 up to $160,000	above $214,000 up to $320,000	N/A	$209.80
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$272.70
above $214,000	above $428,000	above $129,000	$335.70

If you have questions about your Part B premium, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If you pay a late enrollment penalty, these amounts may be higher.

Part B Deductible—$147 per year

Medicare Advantage Plans (Part C) and Medicare Prescription Drug Plans (Part D) Premiums

Visit Medicare.gov/find-a-plan to get plan premiums. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also call the plan or your State Health Insurance Assistance Program.

Part D Monthly Premium

The chart below shows your estimated prescription drug plan monthly premium based on your income. If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium.

If your yearly income in 2012 was			You pay (in 2014)
File individual tax return	**File joint tax return**	**File married & separate tax return**	
$85,000 or less	$170,000 or less	$85,000 or less	Your plan premium
above $85,000 up to $107,000	above $170,000 up to $214,000	N/A	$12.10 + your plan premium
above $107,000 up to $160,000	above $214,000 up to $320,000	N/A	$31.10 + your plan premium
above $160,000 up to $214,000	above $320,000 up to $428,000	above $85,000 up to $129,000	$50.20 + your plan premium
above $214,000	above $428,000	above $129,000	$69.30 + your plan premium

2014 Part D National Base Beneficiary Premium—$32.42

This figure is used to estimate the Part D late enrollment penalty and the income-related monthly adjustment amounts listed in the table above. The national base beneficiary premium amount can change each year. See your Medicare & You handbook or visit Medicare.gov for more information.

For more information about Medicare costs, visit Medicare.gov.

CMS Product No. 11579
Revised October 2013

Transition to 2014 Medicare Part D Prescription Drug Plans

For Fully Subsidized Beneficiaries in NYS

2014 Federal Medicare Part D Low-Income Subsidy (LIS) for NYS: $37.23

	Plan Name (and ID Number)	Company Name	$0 Premium with Full Low-Income Subsidy?	Monthly Drug Premium	+ 2014 Benchmark Plan – premium fully covered for individuals with full low-income subsidy **+ New Benchmark Plan for 2014 – premium fully covered for individuals with full low - income subsidy** ***– Plan no longer available/no longer a benchmark plan***
					Comments/Action Needed
+	**AARP MedicareRx Saver Plus (S5921-379)**	**UnitedHealthCare**	**YES**	$23.40	**+ New Benchmark Plan for 2014 – premium fully covered for individuals with full low - income subsidy**
-	**Aetna CVS/Pharm Prescription Drug Plan (S5810-037)**	**Aetna Medicare**	**NO**	$61.40	***– Plan no longer a benchmark plan***
+	**Cigna HealthSpring Prescription Drug Plan – Reg 3 (S5932-004)**	**Cigna-HealthSpring Prescription Drug Plan**	**YES**	$37.90	Remains a benchmark. No action needed except compare medications against 2014 formulary. **Name Changed from HealthSpring Prescription Drug Plan**
+	**CIGNA Medicare Rx Secure (S5617-013)**	**CIGNA Medicare Rx**	**YES**	$36.80	Remains a benchmark. No action needed except compare medications against 2014 formulary. This plan covers all 20 most commonly used drugs for individuals served by OPWDD.
-	**EnvisionRxPlus Silver (S7694-003)**	**EnvisionRx Plus**	**NO**	$41.40	***– Plan no longer a benchmark plan***
+	**Express Scripts Medicare Value (S5983-004)**	**Express Scripts Medicare**	**YES**	$36.40	Remains a benchmark. No action needed except compare medications against 2014 formulary. This plan covers all 20 most commonly used drugs for individuals served by OPWDD.
-	**First Health Part D Essentials (S5569-007)**	**First Health Part D**	**YES**	$43.10	***– Plan no longer a benchmark plan***
-	**First United American Select (S5580-006)**	**First United American Life Ins. Co.**	**YES**	$40.10	***– Plan no longer a benchmark plan***

Transition to 2014 Medicare Part D Prescription Drug Plans

For Fully Subsidized Beneficiaries in NYS

2014 Federal Medicare Part D Low-Income Subsidy (LIS) for NYS: $37.23

+	**Humana Preferred Rx Plan (S5552-004)**	**Humana Insurance Company of New York**	**YES**	$25.80	Remains a benchmark. No action needed except compare medications against 2014 formulary. Name changed from **Humana Walmart – Preferred Rx Plan**
-	**Silverscript Basic (S5601-006)**	**Silverscript**	**YES**	$34.30	Remains a benchmark. No action needed except compare medications against 2014 formulary. *This plan is under a CMS sanction for 2013 –* ***Silverscript may begin enrolling beneficiaries beginning February 1, 2014.***
-	**SmartD Rx Saver (S0064-003)**	**SmartD Rx**	**YES**	$39.00	Remains a benchmark. No action needed except compare medications against 2014 formulary. *This plan is under a CMS sanction – current enrollees may remain in plan, but no new enrollees are allowed.*
-	**SmartSaver RX (S1140-001)**	**HealthNow New York, Inc.**	**NO**	$42.90	– ***Plan no longer a benchmark plan***
+	**Wellcare Classic (S5967-140)**	**Wellcare**	**YES**	$29.00	Remains a benchmark. No action needed except compare medications against 2014 formulary.

NOTES:

- People enrolled in Medicare and Medicaid are fully subsidized beneficiaries and will pay no monthly premium for basic benchmark plans.
- To use the chart, identify the Part D Plan in which an individual is enrolled and refer to the comments to identify what action might be necessary to ensure the individual's prescription needs are met by a Part D Plan in 2014.
- LIS = Low Income Subsidy
- NYS Regional Benchmark (maximum premium subsidy for LIS beneficiaries) for 2014 is $37.23.
- CMS advises to enroll/change plans by December 7 to be effective for 1/1/14.
- No co-pays for individuals in Long-Term Care Facilities (LTC) like Intermediate Care Facilities (ICF); also effective 1/1/12 for individuals enrolled in the HCBS Waiver.
- Review the Annual Notice of Change (ANOC) (sent out by PDPs to all members by 10/31/13) for formulary changes that may affect an individual and change plans as needed.
- Comprehensive formularies are available on plan websites and www.medicare.gov.
- If an individual residing in an OPWDD residential program remains in a former benchmark plan and there is a premium or partial premium due, the residential provider will be responsible for paying the premium or partial premium.

Information compiled from various sources without warranty or representation as to the accuracy or completeness of information.
See http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/ *for 2014 Landscape of Plans.*

2014 MEDICARE PART D COST SHARING

2014	Typical Part D Beneficiary	Dual Eligible			Other Low Income (Non Dual Eligible)	
		ICF	Other			
			Income ≤ 100% FPL (full subsidy)	Income > 100% FPL (partial subsidy)	Income under 135% FPL & asset eligible (full subsidy)	Income under 150% FPL & asset eligible (partial subsidy)
Annual Deductible	$310	$0	$0	$0	$0	$63
Monthly Premium	$32.40 national average premium *	$0	$0	$0	$0	Sliding scale
Cost Sharing (co-pay)	25% of drug costs between $310 - $2,850 **(**$635 out-of-pocket)	$0	$1.20/$3.60 co-pay (HCBS Waiver enrollees pay $0)	$2.55/$6.35 co-pay (HCBS Waiver enrollees pay $0)	$2.55/$6.35 co-pay	The lesser of 15% of drug cost or plan's co-pay
Initial Coverage Limit	$2,850	no limit	no limit	no limit	no limit	no limit
Coverage Gap ("Donut Hole")	72% of cost of brand name/47.5% of cost of generics ** between $2,850 - $6,455 ($3,605 out-of-pocket)	$0	$0	$0	$0	$0
Catastrophic Coverage ($6,455 catastrophic threshold)	The greater of 5% of drug cost or $2.55/$6.35 co-pay or 5% of cost (Medicare pays 95%)	$0	$0	$0	$0	$2.55/$6.35 co-pay

* Average premium available from Part D plans nationally; this figure is used to calculate the late-enrollment penalty. 2014 Benchmark or fully subsidized plans for dual eligible persons in NYS have premiums of $37.23 or less (full subsidy for basic plan premiums up to $37.23).

** Enrollees may pay a discounted amount on drugs while in the "donut hole"; for generics, beneficiary pays 72%, and for brand name drugs, beneficiary pays 47.5%. When calculating out-of-pocket drug costs, the discounted amount paid for generics is applied; for brand name drugs, the full retail cost is applied.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

MEDICARE SAVINGS PROGRAM
APPLICATION

(Please Print Clearly And Do Not Write In Dark Shaded Area)

	First Name	M.I.	Last Name			HOME PHONE
APPLICANT						
HOME ADDRESS Is this a Shelter? Yes __ No__	Street	Apt.	City	State	Zip Code	County
MAILING ADDRESS *(If different from above)*	Street/P.O. Box	Apt.	City	State	Zip Code	County

NAMES (*List your name first. Include aliases and maiden name*)

	First	M.I.	Last	Date Of Birth	Sex	Social Security Number	Race/Ethnic Code
SELF							
SPOUSE							
CHILD*							

**If under 18 years of age. Attach extra sheet if necessary to list additional children.*

Race/Ethnic affiliation codes: **B -** Black, not of Hispanic origin **W -** White, not of Hispanic origin **H –** Hispanic **U -** Unknown **A -** Asian or Pacific Islander **I -** American Indian/Alaskan Native **O –** Other

Are you a U.S. Citizen? __Yes __No

If No, do you have satisfactory immigration status? Include Alien Number, Date of Status, and Date Entered Country, if applicable. __Yes __No

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

Is your spouse a U.S. Citizen? __Yes __No

If No, does your spouse have satisfactory immigration status? Include Alien Number, Date of Status, and Date Entered Country, if applicable. __Yes __No

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

APPLICANT'S MEDICARE INFORMATION Medicare # _____(*From red and blue Medicare card*)

Do you have Medicare Part A? __Yes __No Effective Date _____

Do you have Medicare Part B? __Yes __No Effective Date _____

SPOUSE'S MEDICARE INFORMATION, if applying Medicare # _____(*From red and blue Medicare card*)

Does spouse have Medicare Part A? __Yes __No Effective Date _____

Does spouse have Medicare Part B? __Yes __No Effective Date _____

Would you like us to consider providing retroactive reimbursement of your Medicare premium? __Yes __No

Do you or your spouse pay any health insurance premiums other than Medicare? __Yes __No Who? _____ Monthly Amount $_____

Do you or your spouse pay child/spousal support? __Yes __No Who? _____ Monthly Amount $_____

Do you or your spouse receive payments from or are named beneficiary of a trust? __Yes __No Who? _____ Value $_____

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc.

Names of Applicant, Spouse, or Child under 18 (*Attach an extra sheet if necessary*)	**Who Provides the Money?** (*Name/source of Income*)	**What Amount?**	**How Often?** (*weekly, two weeks, monthly*)
		$	
		$	
		$	

Do you want to receive notices in: __ **English Only** __ **Spanish and English**

DOH-4328 (6/08)

PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT

PENALTIES: I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid benefits or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Medicaid or if you conceal or fail to disclose facts that would effect the right of someone for whom you have applied to obtain or continue to receive Medicaid benefits; and such benefits must be used by the other person and not for yourself.

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

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

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

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

CERTIFICATION: In signing this application, I swear and affirm that the information I have given or will give to the Department of Social Services as a basis for Medicaid is correct. I also assign to the Department of Social Services any rights I have to pursue support from persons having legal responsibility for my support and to pursue other third-party resources. I understand that Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

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

Applicant/Representative
Signature X _____ Date _____

Spouse Signature X _____ Date _____

Representative Address, Phone Number and Relationship _____

_____

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program please sign on the following line.

I consent to withdraw my application _____ Date _____

SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION: x			DATE:	EMPLOYED BY:		
Eligibility Determined By Worker: _____ (DATE)				Eligibility Approved By: _____ (DATE)		
CENTRAL/OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NO	REUSE IND.
CASE NAME		DISTRICT		REGISTRY NO.		VER.
Effective Date _____ MA Disp. Denial Withdrawal				REASON CODE	PROXY: Yes No	

DOH-4328 **(6/08) Reverse**

Region 2 PDP Complaint Referral

Secure Fax line (212) 264-1022

Plan Name: _____

Date of Complaint _____

State _____

Is the beneficiary completely out of medication and unable to get it? _____

_____

Caller Name _____

Beneficiary Name: _____

Date of Birth _____

HICN _____

LIS Eligible _____

Call Back # _____

Preferred Call Back Time _____

Language _____

Drug(s) information: _____

Reason card didn't work at pharmacy _____

_____

Pharmacy Name _____

Pharmacy Street Address _____

_____

_____

Pharmacy City _____

Pharmacy State _____

Pharmacy Zip _____

Pharmacy Phone _____

Plan Contract _____

Plan Member _____

PBP Number _____

Prescription Discount Drug Card? _____

Complaint Summary _____

_____

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION/RECERTIFICATION

SNAP is the new name for the Food Stamp Program

Use this form if Applying For SNAP Only

If you are only applying for SNAP you can use this shorter application. If you would like to apply for other benefits such as Temporary Assistance, Child Care Assistance, Home Energy Assistance or Medicaid please ask for a different application.

This application can only be used to apply for SNAP.

When You Are Applying For SNAP

- You can file an application the same day you receive it. If you are eligible, benefits will be provided back to the filing date of your application.
- You can file your application before you have an interview.
- We must accept your application if, at a minimum, it contains your name, address (if you have one), and a signature. This information will establish your application filing date. However, the application process, including the interview and a signature on page 5 of the application/recertification must be completed for us to determine your eligibility.
- You can apply for and get SNAP for eligible household member(s) even if you or some other members of your household are not eligible for benefits because of immigration status. For example, ineligible alien parents can apply for SNAP for their children and receive benefits for their eligible children.
- You can still apply and be eligible for SNAP even if you have reached your Temporary Assistance time limits.

Need SNAP Benefits Right Away? You May Be Eligible For Expedited Processing of your SNAP Application.

If your household has little or no income or liquid resources, **or** if your rent and utility expenses are more than your income and liquid resources, **or** you are a migrant or seasonal farmworker with little or no income or resources when you apply, you may be qualified to receive SNAP within 5 calendar days after the date that you apply. Your worker will always review your circumstances to see if you are qualified for expedited processing of your SNAP application. A process is in place to issue SNAP benefits to all eligible households who meet the standards for expedited service.

Where You Can Apply For SNAP

If you live **outside of** New York City, call or visit the social services district in the county where you live and ask for an application package. You can get the address and phone number by calling toll free **1-800-342-3009, or apply on-line at myBenefits.ny.gov**.

If you live in **New York City** and you are **not** also applying for Temporary Assistance, call or visit any SNAP Office and ask for an application package. You can get the address and phone number by calling **1-718-557-1399** or toll free **1-800-342-3009, or apply on-line at myBenefits.ny.gov.**

Having Problems Coming To Us For A SNAP Appointment?

If it is difficult for you to come in for a SNAP application appointment (reasons may include employment, health issues, transportation or child care problems), you may have someone else apply for you, or you may apply on-line at myBenefits.ny.gov. You also can mail us your application or drop it off and, in some circumstances; we can interview you by telephone.

Please contact your social services district if you have any questions, to see if you are eligible for a telephone interview, **or if you need to reschedule an interview.**

NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

SNAP APPLICATION / RECERTIFICATION

Application Date	Interview Date	Center/Office	Unit	Worker	Case Type	Case Number	Registry Number	Version	Lifeline	☐ Apply ☐ Recertify	Lang

Name: _____ Telephone Number: _____ Other phone where you can be reached: _____

Residence Address: _____ Apt.# ____ City _____, NY Zip Code _____

Mailing Address (if different) _____ Apt.# ____ City _____, NY Zip Code _____

Other Name: _____ Are You: ☐ Applying **or** ☐ Recertifying Do you want to receive notices in: ☐ Spanish **and** English **or** ☐ English **Only**

1

We must accept your application if, at a minimum, it contains your name, address (if you have one), and signature in this box. →

APPLICANT/REPRESENTATIVE SIGNATURE

DATE SIGNED

2

List everyone who lives with you even if they are not applying. List yourself first.

LN	First Name	MI	Last Name	Social Security Number (SSN) of applying member (If none, write "NONE")	Date of Birth	Marital Status	Sex M or F	Is this person applying? Yes	Is this person applying? No	Relationship to you	Do you buy and/ or prepare food with this person? Yes	Do you buy and/ or prepare food with this person? No	Hispanic or Latino? Yes	Hispanic or Latino? No	Enter Y (Yes) or N (No) for each race* I	A	B	P	W	U
1								✓		self	✓									
2																				
3																				
4																				
5																				
6																				
7																				
8																				

3

*Race/Ethnic Codes: **I** – Native American or Alaskan Native, **A** - Asian, **B** – Black or African American, **P** – Native Hawaiian or Pacific Islander, **W** – White, **U** – Unknown (**MA Only**)

Are you and is everyone living with you a US citizen? ☐ Yes ☐ No If No, who is not a citizen? _____

Has a court issued a warrant because it found that you or anyone living with you is fleeing to avoid prosecution, custody or confinement for a felony or an attempted felony? ☐ Yes ☐ No

Are you or is anyone living with you in violation of probation or parole according to a court? ☐ Yes ☐ No

Have you or has anyone living with you ever been disqualified from receiving SNAP because of fraud or intentional program violation? ☐ Yes ☐ No

Are you or is anyone in your household applying for or receiving SNAP or Temporary Assistance in another place? ☐ Yes ☐ No

Are you or is anyone living with you blind, disabled or pregnant? ☐ Yes ☐ No If Yes, who _____

Are you or is anyone living with you a veteran? ☐ Yes ☐ No If Yes, who _____

Do you or does anyone live in a drug or alcohol treatment center, State-certified group living facility or State-certified supervised/supportive apartment? ☐ Yes ☐ No

If you are recertifying for SNAP, list on the Page 6 what has changed since your last application or recertification *(such as moved, had a baby, someone moved in or out of your household)*

4

325

You may use the page 6 if you need more room or there is other information that you think we might need.

Go to Page 2

INCOME

List ***ALL*** your income and the income of anyone living with you. This includes, but is not limited to **wages, income from self-employment (for example: babysitting, cleaning, income from a roomer or boarder) child support, pensions, veterans benefits, disability, social security or SSI, grant for scholarships for rent or food, Temporary Assistance, and income from friends or relatives.**

Name of Person Receiving Income	Source of Income	Hours Worked Per Month	How Often is it Received? *(for example, weekly, bi-weekly, monthly)*	Gross Amount Received Before Deductions

Do you or does anyone living with you have child/dependent care costs related to employment or training? ☐ Yes ☐ No *If Yes, who* _____ .

Amount paid $ _____. How often paid *(e.g., weekly, monthly)* _____.

Have you or has anyone living with you changed or quit jobs or reduced any form of income in the last 30 days – including reduced work hours or income? ☐ Yes ☐ No

Do you or does anyone living with you have any potential income that has not yet been received? ☐ Yes ☐ No If *Yes, explain on Page 6.*

5

Do you or does anyone living with you receive a Personal Needs Allowance (PNA) or a Meal Allowance? ☐ Yes ☐ No *If Yes, who* _____ .

Have you or has anyone in your household set aside any income under "PASS: Plan To Achieve Self Support" approved by the Social Security Administration?

☐ Yes ☐ No *If Yes, who* _____ .

Are you or is anyone living with you participating in a strike? ☐ Yes ☐ No If *Yes, who* _____ .

RESOURCES

Resources do not affect the eligibility of most households applying for SNAP. However, some resource information is used to determine if you qualify for expedited processing of your application.

How much money does everyone in your household have? *(For example, on your person; in your home, in checking and savings accounts, or other locations, including jointly held accounts)* $_____ Belongs to _____ .

Other financial assets? *(For example, stocks, bonds, retirement accounts, savings bonds, mutual funds, IRAs, trust funds, money market certificates)* ☐ Yes ☐ No

If Yes, amount $_____ *Type* _____ *Owner* _____.

6

How many cars, trucks or other vehicles do you or anyone in your household have?

___ **#1** *Year* _____ *Make* _____ *Model* _____ *Owner* _____

___ **#2** *Year* _____ *Make* _____ *Model* _____ *Owner* _____

Do you or anyone applying own any property including your own home? ☐ Yes ☐ No if yes, *list property*_____ *Owner* _____

Has anyone applying sold, given away or transferred cash or property in the last three months to qualify for SNAP? ☐ Yes ☐ No

LIVING ARRANGEMENTS AND EXPENSES

Check all the descriptions that apply to your household:

☐ Own home or paying for home ☐ Renting ☐ Migrant/seasonal farmworker ☐ No permanent residence ☐ Live with relatives or friends

List expenses:

7

Monthly rent or mortgage payment $ _____ Tax on home per year $ _____ Insurance on home per year $ _____.

Pay separately for Heat? ☐ Yes ☐ No If yes, specify type of heating: ☐ Gas ☐ Electric ☐ Oil ☐ Wood ☐ Coal ☐ Propane ☐ Other *(list)* _____

Heat Co. Name _____ Heat Co. Acct. No. _____

You may use the page 6 if you need more room or there is other information that you think we might need.

Go to Page 3

LIVING ARRANGEMENTS AND EXPENSES (Cont'd)

Pay for air conditioning, either in your electric bill or as a separate fee? ☐ Yes ☐ No

Pay separately for utilities *(other than heating/cooling)?* ☐ Yes ☐ No *(for example, lights, cooking gas, washer/dryer fees, garbage/trash, water, initial installation of utilities)*.

Does anyone else pay any of these expenses for you *(some examples are Section 8 or other subsidy program)*?

☐ Yes ☐ No *If yes, who pays what?* _____ .

Do you or does anyone living with you pay court-ordered child support? ☐ Yes ☐ No *If yes, who* _____

Name(s) of child(ren) support is being paid for _____

Payment amount $_____ Frequency of payments *(for example, weekly, bi-weekly, monthly)* _____

Are you, and/or anyone living with you, blind/disabled or at least age 60? If so, does such person have medical bills? ☐ Yes ☐ No *If yes, list on the page 6 what they are for, how much and who is responsible for payment.*

Are you, and/or anyone living with you, on Medicaid with a spendown? ☐ Yes ☐ No *If yes, who* _____ *Amount $* _____

Are you, and/or anyone living with you *(16 years old or older)* enrolled in school or training? ☐ Yes ☐ No *If yes, who* _____ *where* _____

You may use the page 6 if you need more room or there is other information that you think we might need.

READ THE IMPORTANT INFORMATION BELOW

SNAP PENALTY WARNING – Any information you provide in connection with your application for SNAP will be subject to verification by Federal, State and local officials. If any information is incorrect, you may be denied SNAP. You may be subject to criminal prosecution for knowingly providing incorrect information.

You will **never** be able to get SNAP again if you are found guilty in a court of law for the second time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for SNAP; **or** found guilty in a court of law of selling or getting firearms, ammunition or explosives in exchange for SNAP; **or** found guilty in a court of trafficking in SNAP worth $500 or more. Trafficking includes the illegal use, transfer, acquisition, alteration or possession of SNAP, authorization cards or access devices; **or** found guilty of committing a third Intentional Program Violation (IPV).

You will not be able to get SNAP for two years if you are found guilty in a court of law for the first time of buying or selling controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) in exchange for SNAP.

If you have committed your: ■ First IPV, you will not be able to get SNAP for one year. ■ Second IPV, you will not be able to get SNAP for two years.

A court could also bar you from receiving SNAP for an additional 18 months. If you make a false statement about who you are or where you live in order to get multiple SNAP benefits, you will not be able to get SNAP for ten years (or **permanently** if this is the third IPV).

You may be found guilty of an IPV if you make a false or misleading statement, or misrepresent, conceal or withhold facts; **or** commit any act that constitutes a violation of Federal or State law for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of SNAP benefits, authorization cards or reusable documents used as part of the Electronic Benefit Transfer (EBT) system.

You could also be fined up to $250,000, sent to jail for up to 20 years, or both.

Anyone who is fleeing to avoid prosecution, custody or confinement for a felony, or who is violating a condition of probation or parole, is not eligible to receive SNAP.

If you get more SNAP benefits than you should have (overpayment), you must pay them back. If your case is active, we will take back the amount of the overpayment from future SNAP benefits that you get. If your case is closed, you may pay back the overpayment through any unused SNAP benefits remaining in your account, or you may pay cash.

READ THE IMPORTANT INFORMATION BELOW *(cont'd)*

If you have an overpayment that is not paid back, it will be referred for collection in a number of ways, including automated collection by the federal government. Federal benefits (such as Social Security) and tax refunds that you are entitled to receive may be taken to pay back the overpayment. The debt will also be subject to processing charges.

Any expunged SNAP benefits will be put towards your overpayment. If you apply for SNAP again, and have not repaid the amount you owe, your SNAP benefits will be reduced if you begin to get them again. You will be notified, at that time, of the amount of reduced benefits you will get.

CONSENT – I understand that by signing this application form I agree to any investigation made by the New York State Office of Temporary and Disability Assistance or my local social services district to verify or confirm the information I have given or any other investigation made by them in connection with my request for SNAP. If additional information is requested, I will provide it. I will also cooperate with State and Federal personnel in a SNAP Quality Control Review.

CONSENT FOR RELEASE OF CONFIDENTIAL UNEMPLOYMENT INSURANCE (UI) INFORMATION – I authorize the New York State Department of Labor (DOL) to release any confidential information, maintained by DOL for Unemployment Insurance (UI) purposes, to the New York State Office of Temporary and Disability Assistance (OTDA). This information includes UI benefit claims and wage records. I understand that OTDA, along with State and local agency employees working in local social services district offices, will use the UI information for establishing or verifying eligibility for, and the amount of, TA, MA, or FS benefits applied for in this application and for investigations to determine whether I received benefits to which I was not entitled.

SUA (STANDARD UTILITY ALLOWANCE) INFORMATION – I understand that SNAP recipients are categorically income eligible for the Home Energy Assistance Program (HEAP). If I am not included in the annual automatic HEAP payment process for certain SNAP recipients, my household intends to apply for a HEAP benefit within the next 12 months. If I decide not to apply for HEAP within the next 12 months, I will let my worker know.

TELEPHONE ALLOWANCE INFORMATION – I understand that SNAP recipients are eligible for a telephone allowance if they pay to use a home phone, cell phone, phone, phone calling card or coin operated pay phone. If I do not have any cost to make phone calls, I will let my worker know.

CHANGES – I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangement, pregnancy status or address to the best of my knowledge or belief in accordance with my reporting requirements.

REQUIREMENT TO REPORT/VERIFY HOUSEHOLD EXPENSES – I understand that my household must report child care and utility expenses in order to get a SNAP deduction for these expenses. I further understand that my household must report and verify rent/mortgage payments, property taxes, insurance, medical expenses and child support paid to a non-household member in order to get a SNAP deduction for these expenses. I understand that failure to report/verify the above expenses will be seen as a statement by my household that I/we do not want to receive a deduction for those unreported/unverified expenses. A deduction for these expenses may make me eligible for SNAP or may increase my SNAP benefits. I understand that I may report/verify these expenses at any time in the future. This deduction would then be applied to the calculation of SNAP in future months in accordance with the rules for change reporting and processing changes.

PRIVACY ACT STATEMENT – COLLECTION AND USE OF SOCIAL SECURITY NUMBER (SSN) – The collection of SSN's is authorized for each household member with respect to SNAP pursuant to the Food Stamp Act of 1977 (as amended, 7 US Code 2011-2036). The information we collect will be used to determine whether your household is eligible or continues to be eligible for benefits. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. The information will be used to check identity, to verify earned and unearned income, and to determine if applicants or recipients can receive money or other help. The information may be disclosed to State and Federal agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

If you or anyone applying/recertifying does not have an SSN, a SSN must be applied for at the Social Security Agency.

READ THE IMPORTANT INFORMATION BELOW *(cont'd)*

CITIZENSHIP/IMMIGRATION STATUS– I swear and/or affirm under penalty of perjury that the information I have provided about the citizenship and immigration status of my self and everyone living with me is true and correct. I understand that any information I provide to verify the immigration status of anyone applying for SNAP may be checked for authenticity with the United States Citizenship and Immigration Services.

***For SNAP*,** citizenship must be documented only if questionable.

NON-DISCRIMINATION NOTICE – In accordance with Federal Law and U.S. Department of Agriculture (USDA) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political belief, or disability. To file a complaint of discrimination write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

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LIFELINE: For applicants/recipients of SNAP: The Office of Temporary and Disability Assistance may or may not release your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate.

If you *do not* want this information released, check this box ☐

You may contact your telephone service provider directly for enrollment in the discounted rate Lifeline Service.

Medicaid-**only** applicants/recipients must contact their telephone service provider directly for enrollment in the discounted rate Lifeline Service.

AUTHORIZED REPRESENTATIVE – You can authorize someone who knows your household circumstances to **apply** for SNAP for you. You can also authorize someone outside your household to get SNAP benefits for you and to use them to buy food for you. If you would like to authorize someone, you must do so in writing. You may do so by printing the person's name, address and phone number below. When an Authorized Representative is applying on behalf of a SNAP Household that does not reside in an institution, both the Authorized Representative and the SNAP Head of Household or other responsible adult member of the household must sign and date the signature sections at the bottom of this page.

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IF YOU WOULD LIKE TO AUTHORIZE SOMEONE, PRINT THE PERSON'S NAME, ADDRESS AND TELEPHONE NUMBER, AND SIGN BELOW.

Name _____ Address _____ Phone _____

CERTIFICATION: I swear and/or affirm under the penalties of perjury that the information I have given or will give to the local Social Services district is correct. <u>Your signature is required below to complete the application process</u>.

APPLICANT SIGNATURE X	DATE SIGNED
Authorized Representative SIGNATURE X	DATE SIGNED

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IF YOU HELPED COMPLETE THIS APPLICATION / RECERTIFICATION FOR SOMEONE ELSE, PRINT YOUR NAME AND ADDRESS HERE. YOU MAY ALSO VOLUNTARILY PRINT YOUR TELEPHONE NUMBER.

Name _____ Address _____ Phone _____

Use this area for additional information:

Who: _____ *Explanation:*

Who: _____ *Explanation:*

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Who: _____ *Explanation:*

I CONSENT TO WITHDRAW MY APPLICATION/RECERTIFICATION. I understand that I may reapply at any time.

SIGNATURE	DATE

12

For Agency Use Only

Eligibility Determined by _____ Date _____

Signature of Person Who Obtained Eligibility Information: _____ Date _____

Employed by: ☐ Social Services District ☐ Provider Agency

(Specify) _____

Reason _____/_____/_____ ☐ Withdrawal ☐ Denial ☐ Recert. Closing

Eligibility Approved by _____ Date _____

SNAP Authorization Period: From _____ To _____

☐ **IN-PERSON INTERVIEW** ☐ **TELEPHONE INTERVIEW**

Comments:

NEW YORK STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE

HOW TO COMPLETE THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) APPLICATION/RECERTIFICATION AND APPLICANT/RECIPIENT RIGHTS AND RESPONSIBILITIES FOR SNAP

SNAP is the new name for the Food Stamp Program

Use This Form If Applying For SNAP Only

If you are only applying for SNAP you can use this shorter application. If you would like to apply for other benefits such as Temporary Assistance, Child Care Assistance, Home Energy Assistance or Medicaid please ask for a different application.

This application can only be used to apply for SNAP Benefits.

When You Are Applying For SNAP

- You can file an application the same day you receive it. If you are eligible, benefits will be provided back to the filing date of your application.
- You can file your application before you have an interview.
- We must accept your application if, at a minimum, it contains your name, address (if you have one), and a signature. This information will establish your application filing date. However, the application process including the interview and a signature on page 5 of the application/recertification must be completed for us to determine your eligibility.
- You can apply for and get SNAP for eligible household member(s) even if you or some other members of your household are not eligible for benefits because of immigration status. For example, ineligible alien parents can apply for SNAP for their children and receive benefits for their eligible children.
- You can still apply and be eligible for SNAP even if you have reached your Temporary Assistance time limits.

Need SNAP Benefits Right Away? You May Be Eligible For Expedited Processing Of Your SNAP Application.

If your household has little or no income or liquid resources, **or** if your rent and utility expenses are more than your income and liquid resources, **or** you are a migrant or seasonal farm worker with little or no income or resources when you apply, you may be qualified to receive SNAP benefits within 5 calendar days after the date that you apply. Your worker will always review your circumstances to see if you are qualified for expedited processing of your SNAP application. A process is in place to issue SNAP benefits to all eligible households who meet the standards for expedited service.

Where You Can Apply For SNAP Benefits

If you live **outside of** New York City, call or visit the social services district in the county where you live and ask for an application package. You can get the address and phone number by calling toll free **I-800-342-3009, or apply on-line at myBenefits.ny.gov.**

If you live in **New York City** and you are **not** also applying for Temporary Assistance, call or visit any SNAP Office and ask for an application package. You can get the address and phone number by calling **1-718-557-1399** or toll free **I-800-342-3009, or apply on-line at myBenefits.ny.gov.**

Having Problems Coming To Us For A SNAP Appointment?

If it is difficult for you to come in for a SNAP application appointment (reasons may include employment, health issues, transportation or child care problems), you may have someone else apply for you, or you may apply on-line at myBenefits.ny.gov. You also can mail us your application or drop it off and, in some circumstances; we can interview you by telephone.

Please contact the social services district if you have any questions, to see if you are eligible for a telephone interview, **or if you need to reschedule an interview.**

INSTRUCTIONS ON HOW TO COMPLETE THE SNAP APPLICATION/RECERTIFICATION

Please **PRINT** clearly in blue or black ink.

Do **NOT** print in the shaded areas.

Be sure to complete each section.

If you are applying as someone's representative, please print information about that person, not yourself.

SECTION 1: APPLICANT INFORMATION

NAME: PRINT your legal name including your first name, middle initial and last name.
TELEPHONE NUMBER: PRINT your home phone number.
OTHER PHONE: PRINT another phone number where you can be reached, if you have one.
RESIDENCE ADDRESS: PRINT the street, avenue, road, etc., where you now live. PRINT the city you live in. PRINT your zip code.
MAILING ADDRESS: PRINT your mailing address if it is different from your residence.
OTHER NAME: **PRINT** any maiden names, names from a previous marriage, or other names that any person listed has or now uses.

Check (✓) whether you are applying or recertifying for SNAP.
Check (✓) if you wish to receive notices in Spanish **and** English or just English.

SECTION 2: Sign your name and date, **ONLY** if you want to submit your application without completing the next page at this time. You must complete the application and sign on page 5 for us to determine your eligibility.

SECTION 3: HOUSEHOLD MEMBERS INFORMATION:

LIST THE NAMES OF EVERYONE WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU.
PRINT your full name first. Then **PRINT** the names of the other people who live with you:

PRINT the date of birth, Social Security Number (if the individual does not have a SSN, enter "none"), marital status and sex for each person applying.
Check (✓) Yes or No to tell us who is applying.
For **each** person in the household, PRINT how they are related to you (for example: wife, son, friend, etc.).
Check (✓) Yes if that person buys and/or prepares food with you.
Check (✓) Yes or No to indicate if each person applying is Hispanic or Latino.
Enter Y (Yes) or N (No) for each race *.
Race/Ethnic codes: **I –** Native American or Alaskan Native, **A –** Asian, **B –** Black or African American, **P –** Native Hawaiian or Pacific Islander**,** **W –** White **U –** Unknown **(MA ONLY)**
*These answers are optional but, if not completed, the interviewer may have to record them by observation. This information will not affect your eligibility.

SECTION 4: Answer all questions in section 4. Fill in names of individuals who are not U.S. citizens.

SECTION 5: INCOME: List all your income and the income of everyone living with you. PRINT the name of the person receiving the income, the source of income and how often it is received. Income can include: Regular job (wages), income before strike, on-the-job-training, military reserves, national guard, work study, alimony, child support, educational assistance (grants, scholarships, etc.), friends or relatives (other than loans), temporary assistance, pensions or retirement, Supplemental Security Income (SSI), Social Security benefits, veterans benefits, unemployment benefits, worker's compensation, babysitting, taxi driving, cleaning homes or other buildings, farming/ranching, income from a roomer, income from a boarder or arts and crafts.

NOTE: Foster Care Payments and SNAP – You may choose to include the foster care child or adult in the SNAP household. If you do, any associated foster care payments will be counted as income. All other income or resources of the foster care child also will be counted. If you have any questions about this, make sure to ask your worker.

Be sure to answer all other questions in section 5.

SECTION 6: RESOURCES: Resources do not affect the eligibility of most households applying for SNAP. However, some resource information is used to determine if you qualify for expedited processing of your application.

Answer all the questions in Section 6 for yourself and everyone who is applying for SNAP. List the dollar ($) amount or value and the name of the person who has the resource. **Be sure to list any joint holdings**. Resources may include any of the following: cash on hand, cash held by others, checking or savings account, savings bonds, individual retirement account, pension plan, individual development account, stocks/bonds, mutual funds, trust fund, money market certificates, buildings, land, rental property, vacation or recreational property or house other than home.

SECTION 7: LIVING ARRANGEMENTS AND EXPENSES:

PRINT the amount you pay for rent, mortgage, room and board or other housing. List the dollar ($) amount that you pay for your property taxes and homeowner's insurance (including fire insurance).

If you pay for your heat separately, check (✓) what type of heat you have.

Also, indicate if:

- you pay for other utilities separately from your rent/mortgage, have telephone costs or air conditioning costs and if you do, who pays the separate expense?
- anyone pays court-ordered child support and if so, who, how much and the frequency of payments?
- anyone applying has any medical bills such as in-home nursing service, dentures, hearing aid, eyeglasses, seeing eye dog or service animal, health insurance and medical payments, hospital or nursing care, medical or dental services, prescription drugs or medical transportation?
- anyone in your household is on Medicaid, with a spendown and if so, who and how much?
- anyone in your household is enrolled in school or in a training program and if so, who and where?

Be sure to answer all other questions in section 7.

SECTION 8: LEGAL STATEMENTS: Read this section carefully or have someone read it to you.

For **Lifeline**, SNAP applicants/recipients must check (✓) the box if you ***do not*** authorize the NYS Office of Temporary and Disability Assistance to possibly disclose your name and address to your telephone service provider. Your telephone service provider may or may not use this information to enroll you in their Lifeline Service for a discounted telephone rate. Lifeline is the lowest rate available for basic telephone service from telephone service providers.

Note: NY State Law provides for fine or jail, or both, for a person found guilty of obtaining SNAP by hiding the facts or not telling the truth.

SECTION 9: SNAP AUTHORIZED REPRESENTATIVE: If you want someone from outside your household to get the SNAP benefits or to buy the food for you, PRINT their name, address and phone number.

SECTION 10: SIGNATURES: Sign your name. If you are an Authorized Representative, both you and the head of household must sign and date the signature sections on page 5 of the Application/Recertification.

When an Authorized Representative is applying on behalf of a SNAP Household that does not reside in an institution, **both the** Authorized Representative and the Head of Household or another responsible adult member of the household must sign and date the signature sections on Page 5 of the Application/Recertification.

SECTION 11: ADDITIONAL INFORMATION: Use this section to let us know additional information that you think we might need to know.

SECTION 12: CONSENT TO WITHDRAW: If you decide you no longer wish to apply for SNAP, sign your name and enter date. You may reapply at any time.

Note: **The last page of this application is an application to register to vote. If you would like help filling out the voter registration application form, ask your worker. Applying or declining to register to vote will not affect your eligibility or the amount of assistance that you will be given by this agency.**

Information from your application and interview will be entered and stored in the Welfare Management System (WMS), a statewide computer system. This system is used to improve the management of Social Services Programs and to deter fraud.

READ THE IMPORTANT INFORMATION BELOW

APPLICANT/RECIPIENT RIGHTS AND RESPONSIBILITIES FOR SNAP

Additional information regarding your rights and responsibilities is contained in the Client Information Books (LDSS-4148A; LDSS-4148B and LDSS-4148C). These books can be obtained at your social services district.

AS AN APPLICANT/RECIPIENT OF SNAP YOU HAVE *RIGHTS*:

TO HAVE AN INTERVIEW:

- The interview must be scheduled as promptly as possible in order to determine eligibility and to issue benefits within 30 days of application filing.
- You may bring someone to your interview to interpret for you. If you need an interpreter, the agency will arrange for one. You cannot be denied access to services because you are not fluent in English or hearing or speech impaired.
  Social Services districts may utilize the TTY/TTD relay systems to gain access to services for Hearing or speech impaired applicants/recipients. If you have any special needs you can request special accommodations from your social services district.
- If you have a disability, you have the same right to access and be interviewed for SNAP as someone who does not have a disability.
- You must be told, within 30 days of the date you turned in (filed) your Application for SNAP, if your Application is approved or denied. If you are eligible for expedited processing you must be told within 5 days after the date you turned in (filed) your Application if you are qualified for SNAP.
- You may request that the in-office interview be waived in hardship situations. Hardship generally includes, but is not limited to, illness, transportation difficulties, care of a household member, hardship due to residency in a rural area, prolonged severe weather, or work or training hours that prevent you from coming in during the social services district's office hours. **The in-office interview will be waived, at your request, if all the adult members of your household are elderly or disabled with no earned income.** The agency may waive the in-office interview in favor of a telephone interview or scheduled home visit. In-person interviews may be scheduled in advance at any mutually acceptable location including a household's residence.
- Get a written notice telling you if your application for SNAP is approved or denied:
  - -- If your Application is approved, this notice will tell you the amount of SNAP benefits you will get;
  - -- If your Application is denied, this notice will tell you why and what you should do if you disagree or do not understand this decision.

TO A CONFERENCE AND/OR FAIR HEARING

If you think any decision about your case is wrong, or you do not understand any decision, talk to your worker right away. If you still disagree or do not understand, you have the right to a **Conference** and/or a **Fair Hearing**.

CONFERENCE - A Conference is when you meet with someone other than the person who made the decision about your case. At the Conference this person will review that decision. Sometimes a Conference is the fastest way to solve any problems you may have. We encourage you to ask for one **even if you have requested a Fair Hearing.** However, Conferences are voluntary, and you can request a Fair Hearing even if you do not request a Conference. To ask for a Conference, call or write your social services district.

A CONFERENCE IS NOT A FAIR HEARING. If you are told that your case is being closed, or that your SNAP benefits or other help you are getting will change, and the problem is not settled through a Conference, you must ask for a **Fair Hearing** to keep your SNAP benefits or other help you are getting from being stopped or changed. Your time to request a fair hearing and your right to "aid to continue" will not be extended by requesting or having a conference.

NOTE: A request for a Conference is not a request for a Fair Hearing. If you want a Fair Hearing, you must request one.

READ THE IMPORTANT INFORMATION BELOW *(cont'd)*

FAIR HEARING - A Fair Hearing is a chance for you to tell an Administrative Law Judge from the New York State Office of Temporary and Disability Assistance why you think the decision about your case was wrong. The State will then issue a written decision which will state whether the social services district's decision was right or wrong. The written decision may order the social services district to correct your case.

At a Fair Hearing you will have a chance to explain why you think the decision is wrong.

TIME LIMITS TO ASK FOR A FAIR HEARING - If you want to ask for a Fair Hearing for SNAP, call **right away** because **there are time limits**. If you wait too long, you may not be able to get a Fair Hearing.

NOTE: If your situation is very serious, the New York State Office of Temporary and Disability Assistance will set up a Fair Hearing for you as soon as possible. When you call or write for a Fair Hearing, be sure to explain that your situation is very serious.

If you do get a notice about your case and you want to ask for a Fair Hearing, the notice will tell you how much time you have to ask for the Fair Hearing. **Be sure to read all of the notice carefully.**

If your notice tells you that your SNAP benefits **have been denied, will be stopped or will be reduced, you may ask for a Fair Hearing within** 90 **days from the date of the notice. You may ask for a Fair Hearing if you think you are not getting enough SNAP benefits at anytime within the certification period.**

If you do not get a notice about your case, and your benefits are denied, stopped or reduced you can also ask for a Fair Hearing.

HOW TO ASK FOR A FAIR HEARING

If you do get a notice about your case and you want to ask for a Fair Hearing, the notice will tell you how. **Be sure to read all of the notice carefully.**

If you get a notice telling you that your benefits will be stopped or reduced, and you ask for a Fair Hearing before the **effective date** on your notice, your money or other help will, in most instances, stay the same **("aid continuing")** until the Fair Hearing decision is made. If the notice was not sent before the effective date, and you ask for a Fair Hearing within **10** days of the **postmark date** of the notice, you also have the right to have your money or other help stay the same **("aid continuing")** until the Fair Hearing decision is made.

However, if you do get **"aid continuing"** and you lose the Fair Hearing, you will have to pay back any benefits that you received as "aid continuing" while waiting for the Fair Hearing decision.

If you **do not** want the money or other help you have been getting to stay the same until the Fair Hearing decision is made, you must tell this to the New York State Office of Temporary and Disability Assistance when you call or write for a Fair Hearing.

If you do not get a notice about your case, and your benefits are stopped or reduced, you can still ask for a Fair Hearing. At the same time that you ask for a Fair Hearing, you can ask that your money or other help be restored **("aid continuing")**.

READ THE IMPORTANT INFORMATION BELOW *(cont'd)*

WHAT YOU SHOULD DO FOR A FAIR HEARING

The New York State Office of Temporary and Disability Assistance will send you a notice, which tells you when and where the Fair Hearing will be held.

To help you get ready for the Fair Hearing, you have the right to look at your case record and get free copies of the forms and papers which will be given to the Administrative Law Judge at the Fair Hearing. You can also get free copies of any other papers in your case record which you think you may need for the Fair Hearing. Usually, you can get these papers before the hearing or at the hearing at the latest. If you ask for any papers, and the social services district does not give them to you before or at the hearing, you should tell the Administrative Law Judge about it.

You can bring a lawyer, a relative or a friend to the Fair Hearing to help you explain why you think a decision about your case is wrong. If you cannot go to the Fair Hearing, you can send someone else in your place. If you are sending someone who is not a lawyer to the Fair Hearing, you should give this person a letter to give to the Administrative Law Judge. This letter should tell the Judge that this person is taking your place.

To help you explain at the Fair Hearing why you think the decision is wrong, you should also bring any witnesses who can help you and any information you have such as:

- **Pay stubs**
- **Bills**
- **Receipts**
- **Leases**
- **Doctor's Statements**

Someone from the social services district will also be at the Fair Hearing to explain the decision about your case. You or your representative will be able to question this person and present your side of the case. You or your representative will also be able to question any witnesses who you bring to help you.

If you think you need a lawyer to help you with your Fair Hearing, you may be able to get a lawyer at no cost to you by calling your local Legal Aid or Legal Services Office. For the names of other lawyers, call your local Bar Association.

NOTE: If you ask, you will be able to get back the money you had to pay for public transportation, child care and other necessary expenses to go to the fair hearing. If no public transportation is available, you may be able to get back the money you had to pay for another type of transportation. If you are unable to use public transportation because of a medical problem, you may be able to get back the money you had to pay for another type of transportation. However, you may be asked to provide medical verification.

If you live anywhere in New York State, you may request a Fair Hearing by telephone, fax, online, or by writing to the address below.

Telephone: Statewide toll free request number is 800-342-3334. Please have the notice, if any, with you when you call.

Fax: your Fair Hearing Request to: 518-473-6735

Online: Complete online request form at http://www.otda.state.ny.us.us/oah/forms.asp

READ THE IMPORTANT INFORMATION BELOW *(cont'd)*

In writing: For notices, fill in the supplied space and send a copy of the notice, or write to:

Fair Hearing Section
NYS Office of Temporary and Disability Assistance
Fair Hearings
P.O. Box 1930
Albany, New York 12201-1930 *Please keep a copy of any notice for yourself*

If you live in New York City you may also make your request in person by walking into the office listed below.

Walk-In (New York City Only) Bring a copy of the notice, or ask for a hearing on a matter not based on a notice, to:

Office of Administrative Hearings
Office of Temporary & Disability Assistance
14 Boerum Place
Brooklyn, New York

NOTE: For New York City emergency fair hearings only – Call 800-205-0110. Do not use this telephone number for anything except emergencies. Requests that do not involve emergencies will not be taken at this number.

TO LOOK AT YOUR CASE AND COMPUTER RECORDS:

Once you apply for SNAP or other help, case records and computer records are kept about your case. Usually, you have the right to look at those records. However, you may **not** be able to look at all of the records. Your worker can explain the rules to you.

When you write for copies of your computer records, the Personal Privacy Protection Law requires that New York State agencies, send you your records; **or** tell you why they will not give you your records; **or** tell you they have your request and they will determine if you are allowed to get your records within five working days of when they get your request letter.

REGARDING EMPLOYMENT:

If you do not agree that you are able to work, you should notify the social services district that you believe you should be exempt from participation in work activities. You will be notified of the social services district's determination regarding your claim. If the social services district disagrees with you, you may request a fair hearing to tell an Administrative Law Judge why you think you are not able to work.

If you are required to participate in SNAP work activities, you may be able to get help paying for certain work-related expenses. You also may be able to receive assistance with child care costs.

IF YOU ARE SUSPECTED OF FRAUD

If you find out that you are being investigated because your worker thinks you did not tell the truth about your case, you should talk to a lawyer. If you are charged with welfare fraud in criminal court, the court will, if you are eligible, assign a lawyer to represent you at no cost.

READ THE IMPORTANT INFORMATION BELOW *(cont'd)*

AS AN APPLICANT/RECIPIENT OF SNAP YOU HAVE SEVERAL *RESPONSIBILITIES*:

EMPLOYMENT RESPONSIBILITIES FOR SNAP RECIPIENTS:

Unless you are exempt from work requirements as an applicant for or recipient of SNAP you must comply with certain rules, including participation in work activities and accepting a job. Your worker will explain these rules.

If you do not comply with the work requirements, you may lose your SNAP benefits.

- There are several exemptions from participation in SNAP work requirements. Ask your worker if you qualify for one of the exemptions. You may be required to provide documentation to support your claim.

If you are not exempt from participation in work activities and do not comply with the work requirements, you may lose your SNAP benefits. The length of time you will lose your benefits depends on the number of times you have failed to comply.

ADDITIONAL RESPONSIBILITIES AND REQUIREMENTS FOR SNAP RECIPIENTS WHO ARE ABLE-BODIED ADULTS WITHOUT DEPENDENTS (ABAWDS)

If you are an able-bodied work registrant, you may also be required to meet additional SNAP eligibility requirements. Your worker will explain these requirements and the exemptions from the requirements.

If you are a work registrant and not exempt, you will only be eligible to receive SNAP benefits for three months in every 36 months unless you are meeting the additional requirements.

If you want to continue to receive SNAP benefits beyond the three month limit, you should ask your worker for a qualifying work or training opportunity.

If you lose your eligibility for SNAP because you did not meet the additional requirement for three or more months during which you received SNAP benefits, you may be able to re-establish your eligibility in several different ways. Your worker will explain how to do this.

RESPONSIBILITY TO RESCHEDULE A MISSED INTERVIEW:

As an Applicant/Recipient of SNAP, you have the responsibility of rescheduling a missed interview before the 30th day after the date you applied to avoid losing SNAP.

RESPONSIBILITY TO PROVIDE PROOF

When you are applying for or getting help, you will be asked to provide proof of certain things. Your worker will tell you which of these things you **must** prove. Not all of these things are required for every program. You may have to prove some things for one program and not for another.

If you bring proof with you when you first come in to apply for assistance, you may be able to get help sooner.

If you drop documentation off at the social services district, you should ask for a receipt to prove what documentation you left. The receipt should have your name, the specific documentation that you dropped off, the time, date, district name and the name of the social services worker who provided the receipt.

READ THE IMPORTANT INFORMATION BELOW *(cont'd)*

If you cannot get the proof you need, ask your worker to help you. If the social services district already has proof of the things that do not change, such as your social security number, you do not need to prove them again.

If your worker tells you that you need additional papers and information to find out if you can get help, you must provide that proof. If you cannot get these papers and information, your worker must try to help you.

NON-CITIZEN ELIGIBILITY INFORMATION

Many non-citizens are qualified aliens who are eligible for SNAP. Even if you are not, your children may be eligible. SNAP should not affect your immigration status with respect to any USCIS decision regarding your immigration matter.

You may be eligible for SNAP if you are a United States (U.S.) citizen, a non-citizen U.S. national (people born in American Samoa or Swain Island), or a qualified alien. A qualified alien for SNAP eligibility is:

1. An American Indian born in Canada with at least 50 per centum of blood of the American Indian race under section 289 of the Immigration and Nationality Act (INA), or
2. A member of an Indian tribe that is a federally recognized Indian tribe (25 U.S.C. (450b(e)), or
3. An alien admitted as a Hmong or Highland Laotian, including spouse and dependent child, or
4. A refugee admitted under section 207 of the INA, or
5. An alien granted asylum under section 208 of the INA, or
6. An alien whose deportation has been withheld under section 234(h) of the INA as in effect prior to April 1, 1997, or removal withheld under section 241(b)(3) of the INA, or
7. An alien admitted as a Cuban or Haitian entrant, or
8. An alien who is a victim of trafficking under section 103(8) of the Trafficking Victims Protection Act, or
9. An alien who is on active duty in the U.S. armed forces or, an honorably discharged veteran, their spouse and dependent children, and the un-remarried surviving spouse and unmarried dependent children of an active duty member or veteran who has died, or
10. An alien admitted as an Ameriasian, or
11. An alien lawfully admitted for permanent residence under the INA and who has 5 years in status, or
12. An alien paroled under section 212(d)(5) of the INA for at least 1 year and who has 5 years in status, or
13. An alien or parent or child of an alien who has been battered or subjected to extreme cruelty in the U.S. by a family member and entered the U.S. before 8/22/96 or has 5 years in status, or
14. Aliens also may be eligible for SNAP if:

    - They are lawfully admitted for permanent residence and have earned, or can be credited with 40 quarters of work;
    - They are in a qualified status listed above and receive certain disability or blindness benefits;
    - They are in a qualified status listed above and are under 18 years old;
    - They are lawfully in the U.S. on August 22, 1996 and are now blind or disabled, old, or was born on or before August 22, 1931.

RESPONSIBILITY TO ENROLL IN THE AUTOMATED FINGER IMAGING SYSTEM (AFIS) – IS THIS TRUE FOR FOOD STAMPS?

If you are applying for or receiving Food Stamps Benefits, you may be required to be entered into the Automated Finger Imaging System (AFIS) if you are an adult (18 years of age or older) or if you are the head of household.

OMB APPROVED NO. 0584-0008
Expiration Date: 07/31/2014

USDA Supplemental Nutrition Assistance Program
Application for Meal Services

FOR USDA USE ONLY
FNS Number:
Date Authorized:
Authorization Initials:
Sponsor Type:
County Code:

Part 1 - Meal Service Types
Directions: Review the descriptions below and check the meal service type that describes the meal service. You may only check one box (one meal service type) per application.

Private For-Profit Restaurant or Private For-Profit Meal Delivery Service means private for-profit establishments that contract with an appropriate State or local agency to offer meals at concessional prices to homeless individuals, elderly persons and their spouses or supplemental security income (SSI) recipients and their spouses.	Private For-Profit Restaurant ☐ Private For-Profit Meal Delivery ☐ Franchise Yes ☐ No ☐
Drug and/or Alcohol Treatment Program means any drug addiction or alcoholic treatment and rehabilitation program conducted by a private nonprofit organization or institution, or a publicly operated community mental health center, that is operating under part B of Title XIX of the Public Health Service Act (42 U.S.C. 300x et. seq.).	Private Nonprofit Organization/Institution ☐ Publicly Operated Organization/Institution ☐
Meal Delivery Service means a public or a private nonprofit organization that prepares and delivers meals to elderly persons and their spouses and/or to the physically or mentally handicapped and persons otherwise disabled, and their spouses if they are unable to adequately prepare all of their meals.	Public Meal Delivery ☐ Private Nonprofit Meal Delivery ☐
Communal Dining Facility means a public or private nonprofit establishment that prepares and serves meals for elderly persons and their spouses or for SSI recipients and their spouses.	Public Communal Facility ☐ Private Nonprofit Communal Facility ☐
Homeless Meal Provider means a public or private nonprofit establishment (e.g., soup kitchen, temporary shelter), approved by an appropriate State or local agency, that feeds homeless persons. If the site receives donated food items from USDA, the site must also purchase and serve other food.	Public Establishment ☐ Private Nonprofit Establishment ☐
Shelter for Battered Women and Children means a public or private nonprofit residential facility that serves meals or provides food to battered women and children. If such a facility serves other individuals, part of the facility must be set aside on a long-term basis to serve battered women and children.	Public Facility ☐ Private Nonprofit Facility ☐
Group Living Arrangement means a public or private nonprofit residential setting that serves no more than 16 residents and that is certified by the appropriate State agency(ies) in accordance with 1616(e) of the Social Security Act or standards determined by USDA to be comparable.	Public Facility ☐ Private Nonprofit Facility ☐
Private For-Profit Senior Citizens' Center or Residential Building means a facility that prepares and serves meals to elderly or SSI recipients. Participating residential buildings must be occupied primarily by elderly or SSI recipients.	Senior Citizens Center ☐ Residential Building ☐

You need to complete a separate FNS-252-2 application for each type of meal service you operate.

***Part 2 - Sponsoring Organization or Business**
Directions: All applicants must complete this section.

Name:

Doing Business As (if applicable):

Mailing Address:

City: State: Zip:

Federal Employer Identification Number (EIN), if applicable:

Name of Person Responsible for Operation of Meal Service:
Title:
Telephone: ( )

Fax, optional:

E-mail, optional:

If this is a private for-profit restaurant, private for-profit meal delivery service, or private for-profit senior citizens center or residential building, you must also complete Part 4.

Part 3 - Site Specific Information - Site Where Meals Are Served
Directions: All applicants must complete this section. You must provide information on all meal sites under the meal service's sponsorship.

Number of sites to accept Supplemental Nutrition Assistance Program benefits:

Site Name #1
Location Address:
City: State: Zip:

Check days of operation: M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU ☐

Meals served: Breakfast ☐ Lunch ☐ Dinner ☐

Person Responsible for On-Site Operation, if different from Part 2:

Title:

Telephone:

If a Group Living Arrangement, number of residents served:

Site Name #2
Location Address:
City: State: Zip:

Check days of operation: M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU ☐

Meals served: Breakfast ☐ Lunch ☐ Dinner ☐

Person Responsible for On-Site Operation, if different from Part 2:

Title:

Telephone:

If a Group Living Arrangement, number of residents served:

Site Name #3
Location Address:
City: State: Zip:

Check days of operation: M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ SU ☐

Meals served: Breakfast ☐ Lunch ☐ Dinner ☐

Person Responsible for On-Site Operation, if different from Part 2:

Title:

Telephone:

If a Group Living Arrangement, number of residents served:

List additional sites on a separate sheet of paper and attach, using the same format above.

Part 4 - Ownership Information		☐ **NA**
Directions: Complete this section only if you are a private for-profit restaurant, private for-profit meal delivery service, or private for-profit senior citizens center or residential building.		
Form of Ownership: ☐ Sole Proprietorship ☐ Partnership ☐ Privately-held corporation ☐ Limited Liability Company ☐ Publicly-owned Corporation (if you check this, skip to Part 5)		
Enter primary owner(s) or corporate officer(s) if one or if more people or a private for-profit corporation owns the meal service. In community property states, the spouse's information must also be entered. Community property states are: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, the state of Washington, and Wisconsin. Print names as they appear on the social security card.		
Name (First, Middle, Last):		
Title:	Social Security Number:	
Date of Birth:		
Home Address:		
City:	State:	Zip:
Enter other owner's or officers; information below, if applicable.		
Name (First, Middle, Last):		
Title:	Social Security Number:	
Date of Birth:		
Home Address:		
City:	State:	Zip:
Name (First, Middle, Last):		
Title:	Social Security Number:	
Date of Birth:		
Home Address:		
City:	State:	Zip:

FOR FNS USE ONLY

Part 5 - Agreement and Signature Block

I understand and agree:

- I have the authority to contract for the meal service.
- I have provided truthful and complete information on this form.
- I hereby agree to release to the Department of Agriculture (USDA), by my signature below my tax records and also to allow USDA to verify the accuracy of information submitted with this application.
- Any information I provide may be verified and shared by/with other agencies as described in attachment B. If I provide false information, my application may be denied or withdrawn.
- I accept responsibility to report changes in the meal service's ownership, address, type of business, and operation to FNS.
- I will follow, and ensure representatives will follow, the Supplemental Nutrition Assistance Program regulations.
- I am aware that violations of program rules can result in fines, legal sanctions, withdrawal, or disqualification from the Supplemental Nutrition Assistance Program.
- I accept responsibility on behalf of the meal service for violations of the Supplemental Nutrition Assistance Program regulations, including those committed by any of the meal service's representatives, both paid or unpaid, new, full-time or part-time. These include violations, such as but not limited to:

  - Trading cash for Supplemental Nutrition Assistance Program benefits;
  - Knowingly accepting Supplemental Nutrition Assistance Program benefits from people not authorized to use them;
  - Accepting Supplemental Nutrition Assistance Program benefits as payments on credit accounts or loans;
  - Using Supplemental Nutrition Assistance Program benefits to cover the cost of room and board or treating Supplemental Nutrition Assistance Program customers differently than other customers;
  - Accepting Supplemental Nutrition Assistance Program benefits as payments for ineligible items.

- Participation can be denied or withdrawn if the meal service violates any laws or regulations issued by Federal, State or local agencies, including civil rights laws and their implementing regulations.
- Participation in the Supplemental Nutrition Assistance Program requires that I will not discriminate against any customer on the grounds of race, color, national origin, age, sex, handicap (disability), political belief or religion; and that I will immediately take any measures necessary to make sure that my customers are not discriminated against.
- Any individual or meal service accepting or redeeming Supplemental Nutrition Assistance Program benefits, if not authorized to do so, is subject to substantial fines and administrative sanctions.
- Approval to participate will be automatically withdrawn and the meal service will no longer be able to accept Supplemental Nutrition Assistance Program benefits upon loss of Federal tax-exempt status, cancellation or expiration of its contract with the State or local agency, or loss of its State certification, if required as a condition of eligibility.

I have read, understand and agree with the conditions of participation outlined in the Privacy Act, Use and Disclosure, Penalty Warning and Certification Statements, and agree to comply with all statutory and regulatory requirements associated with participation in the Supplemental Nutrition Assistance Program.

Has the owner(s), manager(s), and/or officer(s) ever had a license denied, withdrawn, or suspended, or been fined for license violations (such as the Supplemental Nutrition Assistance Program, business, alcohol, tobacco, lottery, or health licenses)? If yes, provide an explanation on a separate sheet of paper. ☐ Yes ☐ No

Has any individual involved in the ownership or management of the meal service ever been convicted of any crime? If yes, provide an explanation on a separate sheet of paper. ☐ Yes ☐ No

PENALTY WARNING STATEMENT - The Food and Nutrition Service can deny or withdraw your approval to accept Supplemental Nutrition Assistance Program benefits if you provide false information or try to hide information we ask you to give us. In addition, if false information is provided or information is hidden from the Food and Nutrition Service, the owners of the firm may be liable for a $10,000 fine or imprisoned for as long as five years, or both (7 U.S.C. 2024(f) and 18 U.S.C. 1001).

Print Name: **Print Title:**

Signature: **Date Signed:**

Submit the supporting documentation as requested in Attachment A.

ATTACHMENT A - MEAL SERVICE APPLICATION REQUIRED DOCUMENTATION LIST

Directions: Provide all of the required documentation for the meal service type for which you are applying, along with the completed application form. Please keep attachments A and B for your records.

SECTION A: Private For-Profit Restaurant or For-Profit Meal Delivery Service

Required Documentation: (Provide all of the following)

- Copy of a government issued photo identification card and a copy of a Social Security card, or other verification of Social Security Number, for:

  all owners/partners
  all officer(s) of private corporations
  also provide for spouses of owners/officers if store is located in a community property State (see Part 4 of the application)
  NOTE: Above documentation is not required for publicly-owned corporations

- Copy of the contract with the State agency
- Copy of a valid business license

SECTION B: Alcohol and / or Drug Treatment Program

Required Documentation:

- Proof of tax-exempt status as recognized by the Internal Revenue Service
- Certified by the State agency responsible for the rehabilitation of drug addicts or alcoholics (the State Title XIX agency) as:

  i. Receiving part B Title XIX funding; or
  ii. Operating under part B Title XIX even if no funds are being received; or
  iii. Operating to further the purposes of part B of Title XIX, to provide treatment and rehabilitation of drug addicts and/or alcoholics.

SECTION C: Public or Private NonProfit Meal Delivery Service; Public or Private NonProfit Communal Dining Facility; Public or Private NonProfit Homeless Meal Provider; Shelter for Battered Women and Children

Required Documentation: For the four meal service types listed above, provide proof of the meal service's tax-exempt status as recognized by the Internal Revenue Service.

SECTION D: Group Living Arrangement

Required Documentation:

- Proof of tax-exempt status as recognized by the Internal Revenue Service.
- Certification by the appropriate State agency in accordance with regulations issued under 1616(e) of the Social Security Act or under comparable standards, as determined by the U.S. Department of Agriculture.

SECTION E: Private For-Profit Senior Citizens' Center or Residential Building

Required Documentation:

- If applying as a Residential Building, a signed statement from the owner(s) certifying: (1) that the building is occupied primarily by elderly persons (60 years of age or older) and SSI recipients and that it prepares and serves meals to such persons, and (2) that it does not provide a majority of the residents' meals (over 50 percent of three meals daily) as part of the institution's normal services.

ATTACHMENT B

PRIVACY ACT STATEMENT - **Authority**: Section 9 of the Food and Nutrition Act of 2008, as amended, (7 U.S.C. 2018): section 405(c)(2)(C) of the Social Security Act (42 U.S.C 405(c)(2)(C); and section 6109(f) of the Internal Revenue Code of 1986 (26 U.S.C. 6109(f)), authorizes collection of the information on this application.

- Information is collected primarily for use by the Food and Nutrition Service in the administration of the Supplemental Nutrition Assistance Program;
- Additional disclosure of this information may be made to other Food and Nutrition Service programs and to other Federal, State or local agencies and investigative authorities when the Supplemental Nutrition Assistance Program becomes aware of a violation or possible violation of the Food and Nutrition Act of 2008, as explained in the next section called "Use and Disclosure";
- Section 278.1(b) of the Supplemental Nutrition Assistance Program regulations provides for the collection of the owners' Social Security Number (SSN), Employee Identification Number (EIN) and tax information;
- The use and disclosure of SSNs and EINs obtained by applicants is covered in the Social Security Act and the Internal Revenue Code. In accordance with the Social Security Act and the Internal Revenue Code, applicant social security numbers and employer identification numbers may be disclosed only to other Federal agencies authorized to have access to social security numbers and employer identification numbers and maintain these numbers in their files, and only when the Secretary of Agriculture determines that disclosure would assist in verifying and matching such information against information maintained by such other agency [42 U.S.C. 405(c)(2)(C)(iii); 26 U.S.C. 6109(f)];
- Furnishing the information on this form, including your SSN and EIN, is voluntary but failure to do so will result in denial of this application;
- The Food and Nutrition Service may provide you with an additional statement reflecting any additional uses of the information furnished on this form.

USE AND DISCLOSURE - Routine Uses: We may use the information you give us in the following ways;

- We may disclose information to the Department of Justice (DOJ), a court or other tribunal, or another party before such tribunal when the USDA is involved in a lawsuit or has an interest in litigation and it has been determined that the use of such information is relevant and necessary and the disclosure is compatible with the purpose for which the information was collected;
- In the event that the information in our system indicates a violation of the Food and Nutrition Act or any other Federal or State law whether civil or criminal or regulatory in nature, and whether arising by general statute, or by regulation, rule, or order issued pursuant thereto, we may disclose the information you give us to the appropriate agency, whether Federal or State, charged with the responsibility of investigating or prosecuting such violation or charged with enforcing or implementing the statute, or rule, regulation or order issued pursuant thereto;
- We may use your information, including SSNs and EINs, to collect and report on delinquent debt and may disclose the information to other Federal and State agencies, as well as private collection agencies, for purposes of claims collection actions including, but not limited to, the Treasury Department for administrative or tax offset and referral to the Department of Justice for litigation. (**Note**: SSNs and EINs will only be disclosed to Federal agencies authorized to possess such information);
- We may disclose information to other Federal and State agencies to verify the information reported by applicants and participating firms/meal service providers, and to assist in the administration and enforcement of the Food and Nutrition Act as well as other Federal and State laws. (Note: SSNs and EINs will only be disclosed to Federal agencies authorized to possess such information);
- We may disclose information to other Federal and State agencies to respond to specific requests from such Federal and State agencies for the purpose of administering the Food and Nutrition Act as well as other Federal and State laws;
- We may disclose information to other Federal and State agencies for the purpose of conducting computer matching programs;
- We may disclose information (excluding EINs and SSNs) to private entities having contractual agreements with us for designing, developing, and operating our systems, and for verification and computer matching purposes;
- We may disclose information to the Internal Revenue Service, for the purpose of reporting delinquent retailer and wholesaler monetary penalties of $600 or more for violations committed under the SNAP. We will report each delinquent debt to the Internal Revenue Service on Form 1099-C (Cancellation of Debt). We will report these debts to the Internal Revenue Service under the authority of the Income Tax Regulations (26 CFR Parts 1 and 602) under section 6050P of the Internal Revenue Code (26 U.S.C 6050P);
- We may disclose information to State agencies that administer the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), authorized under section 17 of the Child Nutrition Act of 1966 (CNA) (42 U.S.C. 1786), for purposes of administering that Act and the regulations issued under that Act;
- Disclosures pursuant to 5 U.S.C. 55 2a(b)(12). We may disclose information to “consumer reporting agencies” as defined in the Fair Credit Reporting Act (15 U.S.C. 1681a(f)) or the Debt Collection Act of 1982 (31 U.S.C. 3711(d)(4));
- We may disclose information to the public when a retailer/meal service provider has been disqualified or otherwise sanctioned for violations of the Program after the time for administrative and judicial appeals has expired. This information is limited to the name and address of the store/ meal service, the owner(s) name(s) and information about the sanction itself. The purpose of such disclosure is to assist in the administration and enforcement of the Food and Nutrition Act and Supplemental Nutrition Assistance Program regulations.

Certification and Signature - By signing your name on this application, you are telling us that: (1) you are the meal service principal administrator, executive director, owner or that the meal service owner(s) have asked you to apply for them; (2) the information you and/or the owner(s) gave us on this form, or papers we asked for, is true, (3) you have read and understand all the information on this sheet; (4) you understand that you and the person(s) for whom you are applying are responsible for stopping workers, paid or unpaid, from breaking Supplemental Nutrition Assistance Program rules such as, but not limited to: (a) trading cash for Supplemental Nutrition Assistance Program benefits; (b) taking Supplemental Nutrition Assistance Program benefits from people not allowed to use them; (c) taking Supplemental Nutrition Assistance Program benefits to pay on a credit account or loan; (d) taking Supplemental Nutrition Assistance Program benefits to pay for items not allowed to be paid for with Supplemental Nutrition Assistance Program benefits; (e) treating Supplemental Nutrition Assistance Program customers differently than other customers. We can take away a meal service's right to take Supplemenal Nutrition Assistance Program benefits as payment of food provided at your meal service facility if any owner(s), manager(s) or anyone working in the meal service violates any of the Supplemental Nutrition Assistance Program law or rules.

Public reporting burden for this collection of information is estimated to average 11 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate (0584-0008)or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis, 3101 Park Center Dr., Alexandria, VA 22302. Do not return the completed form to this address.

To file a complaint of Discrimination, write to the USDA, Director, Office of Adjudication, 1400 Independence Ave, SW, Washington, D.C. 20250-9410. Do not send the completed application form to this address.

OPWDD ADVISORY: RESPONSIBILITIES OF VOLUNTARY AGENCIES THAT SERVE AS REPRESENTATIVE PAYEE OR OTHER FIDUCIARY FOR INDIVIDUALS WHO RECEIVE LUMP SUM FEDERAL BENEFITS

It has come to the attention of OPWDD that a number of individuals served by voluntary agencies have received retroactive lump sum benefit payments which require careful attention and planning that is consistent with the individual's needs and choices. Such planning is essential to maintain those individuals' Medicaid eligibility and avoid a claim of incorrectly paid Medicaid. This Advisory provides general information concerning the handling of lump sum payments received for individuals for whom you serve as the Representative Payee or other fiduciary. Typically, these payments are Social Security or Supplemental Security Income benefits issued by the Social Security Administration for retroactive periods.[1] How the retroactive payment is best handled is determined by several factors discussed below. Please note that additional factors may have to be considered depending on the specific individual's circumstances. It is important that agencies review each individual's situation carefully to ensure that all lump sum benefit awards are handled **in the individual's best interests.**

Medicaid –Retroactive lump sum payments are considered income in the month received. As the individual's Representative Payee, your agency must report the amount of the retroactive payment to the appropriate Medicaid district upon receipt of notification that the payment will be issued or the receipt of the payment, whichever occurs first. For individuals in Congregate Care living arrangements (Family Care and Individualized Residential Alternatives) who are subject to community budgeting rules, the responsible Medicaid district is required to provide the individual with timely notification (ten or more days prior to the month coverage will change) prior to changing coverage due to receipt of the payment; therefore, your agency must provide notification to the district in a timely manner. For residents of Intermediate Care Facilities who are subject to chronic care budgeting, the Medicaid district can adjust the Net Available Monthly Income (NAMI) in a future month when the district is not notified until a subsequent month. A prospective NAMI adjustment can be made for a lump sum payment received within six months prior to the month the change in coverage is being made. The only exception to this occurs when the payment is for Social Security benefits for a period that SSI was paid. In that circumstance, the payment will not be treated as income in the month received. If SSI was not received for every month

[1] It is less common for these payments to be issued by other benefit-paying agencies including the Railroad Retirement Board and the Department of Veterans Affairs.

covered by the payment, the portion of the payment for the months SSI was not received will be income in the month received.

Social Security and SSI benefits are considered exempt countable resources for purposes of determining a person's Medicaid eligibility for only nine months following the month of receipt. During those nine months, the monies may be used to meet the individual's wants and needs, which may include such things as vacations, entertainment and expenditures for personal items. The individual, family members and Medicaid Service Coordinator should be involved to assist in making spending decisions consistent with the individual's personal expenditure plan that reflects their choices, interests and needs.. **The funds cannot be used to pay for supplies or services that the agency is required to pay for as detailed in 14 NYCRR 635-9.1.** If the lump sum is in an amount that, in combination with any other funds held on behalf of the individual, would exceed the applicable maximum resource level for an individual -- for SSI ($2000) or Medicaid ($14,250 in 2012), it may be appropriate to seek to establish a Supplemental Needs Trust as well as an Irrevocable Burial Trust (IBT) for the individual's benefit. Establishing an SNT and/or IBT is also appropriate if the lump sum will not be spent down to an amount below the maximum allowable resource level for Medicaid eligibility purposes within the nine month Medicaid exemption period.

IMPORTANT: Any necessary actions to set up a SNT or an IBT must be taken prior to the end of the nine month Medicaid exemption period.

OPWDD strongly urges all providers to closely monitor with great care the receipt of lump sum benefits so that the property rights of individuals with developmental disabilities are fully protected.

Information concerning Medicaid and Trust Funds is available on the Department of Health website (http://www.health.ny.gov/health_care/medicaid/reference/mrg/resources.pdf).

Please note that once the nine month Medicaid exemption period expires, if the individual for whom your agency serves as Representative Payee is over the Medicaid resource level, your fiscal staff should be aware that the individual is not eligible for Medicaid until the resources are reduced to the allowable level. **Your agency must notify the individual's Medicaid District of the excess resources and not claim for services for any period when the individual is not eligible for Medicaid.** The countable resource level is determined on the first day of each month.

If you or your staff have questions regarding specific benefits, contact the benefit paying agency or the appropriate Medicaid District. For questions regarding District 98 Medicaid cases, the list of Revenue Support Field Offices and the contact information is

attached. The contact information for other Medicaid Districts is available using the following link: http://www.health.ny.gov/health_care/medicaid/ldss.htm.

Social Security and SSI – If the individual is under 18 years of age, the retroactive payment may have to be placed in a Dedicated Account. Social Security requires that the representative payee for a disabled child under age 18 who is eligible for large past–due payments (usually any payment covering more than six months of the current benefit rate) open a separate account at a financial institution. The past–due payments will be deposited directly into that "dedicated account", and the use of these funds is restricted only to meet the medical and educational needs of the child. The funds in a Dedicated Account cannot be used for basic monthly maintenance costs such as food, clothing and shelter. Funds in a Dedicated Account are not counted towards eligibility for SSI or Medicaid. SSA should be contacted if there are any questions regarding the use of funds from a Dedicated Account. More information on Dedicated Funds is available on the Social Security website (http://www.socialsecurity.gov/ssi/spotlights/spot-dedicated-accounts.htm).

For individuals over 18 years of age, the payments may be used as described in the Medicaid section above. For SSI beneficiaries, if the money is not spent or placed into a SNT within 9 months after the month of receipt, an overpayment may occur and SSI benefits may stop if countable resources exceed the $2000 ($3000 for a couple) threshold.

If there are any questions concerning the use of Social Security or SSI benefits, your staff should contact SSA (1-800-772-1213) or your agency's contact at the local SSA office.

Railroad Retirement Benefits – Retroactive Railroad Retirement benefits are income in the month received and exempt as a countable resource for nine months following the month of receipt. The funds may be used as described in the Medicaid section above. Questions regarding Railroad Retirement benefits should be referred to the appropriate Railroad Retirement Board Office. Contact information is available at the following link: http://www.rrb.gov/general/contact_us.asp.

Veterans Benefits – Retroactive Veterans benefits are "income" in the month received and a countable resource the month following the month of receipt. If the individual needs or wants any item that costs $1000 or more, the VA must be contacted to request written authorization to use the funds. Before using VA funds for a Supplemental Needs Trust the VA must always be contacted to request written authorization to use the funds to fund the SNT. Questions regarding Veterans benefits should be referred to the Department of Veterans Affairs at 1-800-827-1000.

RECEIPT OF LUMP SUM FEDERAL BENEFITS* BY VOLUNTARY AGENCIES SERVING AS REPRESENTATIVE PAYEE OR OTHER FIDUCIARY FOR INDIVIDUALS
1. Notify the individual's Medicaid District upon receipt of a notice of change in income from the benefit paying agency, or if a notice is not received, upon receipt of retroactive funds or change in income.
2. Determine whether the amount of the retroactive award is an amount which will impact on the individual's eligibility for Medicaid. • The current Medicaid eligibility resource level for an individual effective January 1, 2012 is $14,250; • The current SSI resource level for an individual is $2,000.
3. A retroactive award from Social Security or Railroad Retirement is considered income in the month received and exempt for nine months following the month of receipt.[1]
• Within nine months following the month of receipt of the retroactive Social Security/Supplemental Security Income/Railroad Retirement award: Take action to assist the individual and actively involved family in expending the funds for the individual's needs and interests consistent with the individual's personal expenditure plan; **and** If such expenditures do not provide for the expenditure within the 9 month exemption period of an amount of funds that will maintain the individual's Medicaid eligibility ***or*** if the amount of funds necessary to expend to maintain an individual's Medicaid eligibility will not be expended within such time frame, seek to place the amount in excess of the eligibility level into a Supplemental Needs Trust or other qualifying exception trust.
*For questions regarding specific benefits, contact the benefit paying agency or the appropriate Medicaid District.

[1] For determining Medicaid eligibility, a retroactive award from other benefits is countable income in the month received and a countable resource thereafter.

NOTE: THIS CHART IS INTENDED TO SERVE ONLY AS A GENERAL SUMMARY AND SHOULD NOT BE RELIED UPON AS THE PROVIDER'S SOLE SOURCE OF INFORMATION WHEN ADDRESSING A BENEFIT RECEIVED FOR AN INDIVIDUAL SERVED BY THE AGENCY. EACH INDIVIDUAL'S SITUATION MUST BE REVIEWED CAREFULLY TO ASSURE THAT ANY LUMP SUM BENEFIT PAYMENTS ARE HANDLED IN THE BEST INTEREST OF THE INDIVIDUAL. PLEASE REFER TO THE OPWDD ADVISORY ON THIS SUBJECT AND THE INFORMATION REFERENCED THEREIN FOR ADDITIONAL INFORMATION.

44 Holland Avenue, Albany, NY 12229

For further information, please check the OPWDD website:

www.opwdd.ny.gov

Or call:

(886) 946-9733 (866) 933-4889