

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES
www.opwdd.ny.gov

REPLY TO:

DATE:

NAME:

TABS ID:

Dear

The above named individual has been admitted to our care. We are requesting information from you so that we can determine or review the individual's eligibility for various federal and state benefit programs (Social Security, Medicaid, etc.) and develop sources of reimbursement (insurance, individual's personal ability, etc.) for services provided.

Individuals who have been determined to be eligible for OPWDD services and wish to receive services that Medicaid funds must file for Medicaid and all other benefits for which they may be eligible. In addition, individuals seeking any OPWDD service funded through the Home and Community Based Services Waiver (HCBS Waiver) must pursue and qualify for enrollment in the HCBS Waiver.

Please complete this form to the best of your ability and return it within two weeks. Do not leave blanks; write NO, NONE, UNKNOWN or NOT APPLICABLE (NA) where necessary. If there is not enough space to answer a question, attach a sheet of paper with the additional information. **Please attach photocopies of the individual's birth certificate, Social Security card, passport, marriage license or divorce decree if applicable, and documentation of any income, assets and insurance that you list on the form.** If you send an original document we will photocopy it for our records and return the original document to you.

We will apply for Medicaid if the individual meets the eligibility requirements. For your information, we have attached a notice of EXPLANATION OF THE EFFECT OF TRANSFER OF ASSET(S) ON MEDICAL ASSISTANCE ELIGIBILITY.

Mental Hygiene Law section 43.05 requires that any person or organization having information about an individual receiving services from the Office For People With Developmental Disabilities provide such information upon request. Any information provided about an individual is subject to verification through matching programs with state and federal agencies, such as the Social Security Administration.

If you need assistance or have any questions, please feel free to call me at the telephone number listed above. Thank you for your cooperation.

RESOURCES AND REIMBURSEMENT AGENT

A. IDENTIFYING INFORMATION ABOUT THE INDIVIDUAL

Full Name at Birth		Date of Birth	Social Security Number
Place of Birth (City, State) (Please enclose a copy of the individual's birth certificate.)			U. S. Veteran? <input type="checkbox"/> YES <input type="checkbox"/> NO
Marital Status	Spouse's Name	Date and Place of Marriage/Divorce	
U. S. Citizen <input type="checkbox"/> YES <input type="checkbox"/> 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 and any other proof of lawful residence.			
Is there a court appointed legal guardian, alternate or standby guardian, conservator, or committee for the individual? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, give the name and address. Please attach copies of the legal papers.			

B. INFORMATION ABOUT THE INDIVIDUAL'S INCOME

Was the individual ever employed or did he or she receive wages (including wages from a workshop)? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, is the individual currently employed? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete the following about the current employer(s) and any other employers during the last 3 months.			
Employer(s)	Address		
Does the individual receive income from any source? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, complete the following.			
Income Source	Who is Payee?	Claim Number	Monthly Amount
SOCIAL SECURITY			\$
SUPPLEMENTAL SECURITY INCOME (SSI)			\$
RAILROAD RETIREMENT			\$
VETERANS BENEFIT			\$
CHILD SUPPORT (Please attach copies of court order(s))			\$
OTHER including Civil Service Annuity, Unemployment Insurance, interest from a trust fund, court ordered payment, National Vaccine Injury Award payment, Adoption Subsidies, dividends. Please specify:			\$

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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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.

C. INFORMATION ABOUT THE INDIVIDUAL'S ASSETS (continued)

Does the individual have a bank account(s) (savings, checking, etc.) or credit union account(s)? YES NO
If YES, complete the following. (Attach a sheet if needed.)

Type of Account (Savings, Checking, Other)	Account 1	Account 2
Bank Name and Address		
Account Number		
Title on Account		
Name of Person Receiving Bank Statements or Holding Bankbook		

Does the individual have a Certificate of Deposit, an annuity, 401(k) or other retirement account?
 YES NO If YES, attach a sheet with details.

Does the individual have any cash on hand?
 YES NO If YES, enter the amount:
\$

Does the individual have stocks, bonds or other securities?
 YES NO If YES, attach a sheet with details.

Does the individual have interest in real property?
 YES NO If YES, attach a sheet with details.

Is there a burial fund for the individual?
 YES NO If YES, attach a sheet with details.

Does the individual have any other asset(s)?
 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, please specify below and attach a photocopy of any contract.

D. FUTURE INCOME OR ASSETS FOR THE INDIVIDUAL

Does the individual have an interest in, possible interest in, or expect to receive any of the following?
If you answer YES to any of these items, please specify below and attach a sheet with details if needed.

TRUST FUND YES NO

LAWSUIT SETTLEMENT YES NO

INHERITANCE YES NO

OTHER YES NO

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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Effective Date	Claim Number
Part A Hospital Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO		
Part B Medical Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO		
Part D Prescription Drug Plan <input type="checkbox"/> YES <input type="checkbox"/> NO		
Medicare Advantage Plan <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please provide information about the plan in the space below		
Medicare Advantage Plan Name, Address and Phone Number		
Is the individual covered by health insurance? <input type="checkbox"/> YES <input type="checkbox"/> 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	
If Health Insurance coverage is through a group plan, give 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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
U. S. Veteran If YES, give:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Serial Number			
Claim Number			
Receiving Disability/Retirement Benefit	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, provide the information below or attach a sheet with a detailed list.		
NAME	ADDRESS AND PHONE NUMBER	RELATIONSHIP

The information given is correct to the best of my knowledge.

Signature	Date
Relationship to Individual	Telephone