

MEDICAID ALERT

July 1, 2010

**Revisions to Health Insurance Application
(DOH-4220) and Introduction of the Access NY
Supplement A (DOH-4495A)**

The purpose of this Alert is to familiarize Providers, Client Representatives and Facilitated Enrollers with some of the key changes in the revised DOH-4220, Access NY Health Care application and its companion forms. It also introduces the DOH-4495A, Access NY Supplement A. Certain consumers must complete Supplement A in addition to the Access NY application.

The Access NY Health Care application was revised to support recent changes in policy which eliminate both the resource test for non-SSI-related Medicaid and Family Health Plus applicants and the requirement for a personal interview for individuals applying for Medicaid and Family Health Plus coverage. The revised application incorporates requests for information that may have previously been obtained during the personal interview.

The revised DOH-4220 should be used for all applicants seeking Medicaid/Family Health Plus only, including applicants seeking coverage of long-term care and nursing home care. All entities should begin using the revised DOH- 4220 and Supplement A immediately. MAP will however; continue to accept both the older version of the DOH- 4220 or the LDSS-2921, if submitted.

The revised DOH-4220 application can be accessed in English at:
<http://www.health.state.ny.us/nysdoh/fhplu/application.htm>. The application may be printed in its entirety or in individual sections.

Extensive changes have been made to the DOH-4220. Not all these changes can be fully covered in this Alert. This new application will be discussed as part of the regular trainings held by Eligibility Information Services. If your staff would like further information/training on the new application, you can call (212) 273-0047 to schedule a representative(s) to attend an appropriate training session(s).

I. ACCESS NY HealthCare Application (DOH-4220)

The new DOH-4220 now includes a **SEND PROOF** icon throughout the document to assist applicants in understanding when documentation is needed.

Section A

This section now contains several optional check boxes for a consumer to designate a contact person.
Please note: While there is a check box for a consumer to indicate a second party who they would like to receive notices and correspondence, the downstate version of Welfare Management

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Management System does not currently support this. If a consumer would like her/his notices to be sent to an address other than their residence, they can indicate a mailing address and all correspondence will be sent to that address. For New York City Medicaid consumers, it is not possible to send notices to more than one person or address at this time.

If the applicant checks the box indicating "Discuss my Medicaid application or case, if needed", MAP staff will discuss the status of the submitted application only with the individual indicated.

Section C. Household Income

As part of the revised DOH 4220, SDOH has introduced a new form, Verification of Employment—(copy attached) that can be used if an applicant does not receive pay stubs and needs their employer to verify their income. If an applicant indicates s/he is paid "off the books" and her/his employer refuses to provide a statement of wages, the Self-Declaration of Income form (DOH-4444 - copy also attached) can be completed by the applicant. The DOH-4444 replaces the MAP-2050A form which was previously used for this purpose.

Question 3 of Section C asks "Have you or anyone who is applying changed jobs or stopped working in the last three months?" The applicant's response will be used by MAP to help resolve information received in electronic matches with the Wage Reporting System.

Housing Expenses

The monthly housing expense question has been revised to clarify that it should only include the portion paid by the applicant(s). The applicant's response will be used to help evaluate an applicant's Financial Maintenance. (A separate Alert describes recent changes in policy regarding evaluation of Financial Maintenance.)

A new question was added to ask if the applicant pays for water separately, and if so, to provide a copy of the water bill. If an applicant's water expense is documented, it can be used to increase the allowable income level in some instances. If a dollar amount is supplied but no documentation is received, the applicant will initially be evaluated without the deduction for water expense. Documentation of the expense will only be requested if it affects her/his eligibility.

Section G - Additional Health Questions

Question 1: In this section asks if anyone applying has paid or unpaid medical or prescription bills for this month, or in any of the three months before this month. It also instructs that income documentation be submitted for any month in which they have bills. Even without copies of the bills, if an applicant indicates that s/he has medical bills in any of the previous 3 months and submits income documentation for that period, MAP will determine eligibility for the retroactive period.

Question 2: In this section asks if anyone applying has any unpaid medical or prescription bills older than the previous three months (viable bills). This question was added in case the applicant is determined eligible with excess income. MAP will only require copies of the bills if the applicant uses them to meet a spenddown for current and future coverage.

Question 3: asks if anyone applying moved into the county in the last three months. The applicant's response will help to facilitate the possible transfer of active Medicaid coverage from another New York State county.

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II. SUPPLEMENT A (DOH-4495A)

In addition to completing the Access NY Health Care application, applicants who are age 65 or older, certified blind or certified disabled, not certified disabled but chronically ill, or institutionalized and applying for coverage of nursing home care, must complete Supplement A.

SSI-related applicants applying for Medicaid, but not for coverage of community-based long-term care services, are still subject to the resource attestation policy of 2004 and may attest to their resources. SSI-related applicants applying for Medicaid coverage for community-based long-term care services must submit documentation of the current amount of their resources. These groups of individuals must fill out Sections A through F of Supplement A and sign page 6. Applicants who are age 65 or over, certified blind or certified disabled, or who are institutionalized and applying for coverage of nursing home care, must complete the entire Supplement and sign the last page. If the LDSS-2921 (instead of the DOH-4220) is submitted, applicants are not required to complete Supplement A.

NOTE: In accordance with 10 OHIP/ADM-1, an institutionalized S/CC or ADC-Related applicant who requires temporary nursing home care is budgeted under community rules, and therefore, is not required to complete Supplement A. If the S/CC or ADC-related applicant has a community spouse, spousal rules apply if the institutionalized spouse is in a medical institution and/or nursing facility and is likely to remain in the facility for at least 30 consecutive days. Under spousal rules, there is a resource test and Supplement A must be completed. If an unmarried S/CC and/or ADC-related applicant is in permanent absence status in a medical facility, a disability determination must be completed before eligibility can be established for Medicaid coverage of nursing facility services. The applicant is required to complete Supplement A, unless the LDSS-2921 was submitted.

Section C Adult Home or Assisted Living Facility

This section asks if the applicant is living in adult home, congregate care or assisted living facility. The consumer's response will help to ensure that the appropriate income level is budgeted when her/his case is processed. Applications still need to include proof of the type of residence and level of care.

Section D Resources/Assets

Section D identifies the type of coverage the applicant can apply for and the required income documentation, if any, that must be supplied for each type. Applicants must check one of the boxes.

The directions for this Section advise applicants to provide an explanation of each bank transaction of \$2,000 or more. This now standardizes this amount across New York State counties. However, if MAP identifies that a transfer(s) for less than fair market value may have been made, we may need to review all transactions made during the transfer look-back period.

Applicants who do not need coverage of nursing home care can stop at the end of Section F and sign the last page. If an applicant needs coverage of nursing home care, s/he must also complete Sections G through I and sign the last page.

NEW YORK STATE DEPARTMENT OF HEALTH

Office of Health Insurance Programs

Verification of Employment

Name: _____ App Reg./Case #: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

For Office Use Only

To be completed by the employer:

I certify that _____ works for me as _____
(What do you do?)

This employee is paid each (circle one): Week Two weeks Twice per month

Does the employee have access to New York State Health Insurance? Yes No

Does the employee have dependents enrolled in his/her employer sponsored coverage? Yes No

Please supply the following information:

Last consecutive weeks	Date paid	Gross pay – Include tips, commissions and bonuses
1		
2		
3		
4		

If no longer employed, date last worked: _____

Business name: _____

Business address: _____

City: _____ State: _____

Zip: _____ Business telephone: _____

Employer's name (please print): _____ Title: _____

Employer's signature: _____ Date: _____

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Self-Declaration of Income

Name: _____ App Reg./Case #: _____
 Social Security Number: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

Complete the information below only if you have no other way to document your income. All of the boxes below must be checked and all questions answered. Failure to complete this form may result in denial of your application.

- I get paid in cash.
- I do not get pay checks.
- I do not get pay stubs.
- I cannot get a letter from my employer. Explain why: _____

My cash income is \$ _____ How often (weekly, monthly etc.) _____

Current Employer: _____

Applicants/Recipients must read the following and sign below

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for Public Health Insurance Programs. I understand that program officials may verify information on this form. I also understand that if I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

Signature of Applicant: _____ Date: _____

Facilitated Enrollers must read the following and sign below

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me. I did not modify the information in any way. I understand that if I intentionally falsified information on this form or if I assisted the applicant in falsifying any information, I may lose my job and may be prosecuted under State law.

Name: _____ Signature: _____ Date: _____