NYLAG
New York Legal Assistance Group

This fact sheet posted at
http://www.wnylc.com/health/download/637/ and
http://www.wnylc.com/health/entry/203/

Fast-Track "IMMEDIATE NEED" Medicaid Applications for Personal Care or Consumer-Directed Personal Assistance Services

If you apply for Medicaid in order to enroll in a Managed Long Term Care (MLTC) plan, it can take 3 – 4 months or more before you are actually enrolled in a plan and start receiving home care. The Medicaid application takes about 6 weeks to process, then it takes 2 weeks to schedule a "Conflict Free" assessment by New York Medicaid Choice, then another 2-3 weeks while you ask MLTC plans to schedule a nursing assessment, so that you can select a plan and enroll. The plan must submit the signed enrollment form by the 19th of the month for enrollment to start the 1st of the next month. If you miss that deadline, enrollment is delayed another month.

If you have an IMMEDIATE NEED for Medicaid home care, you can apply at your local Medicaid program and **get Medicaid approved and home care started in 2-3 weeks.** If you don't have Medicaid, you can apply for Medicaid AND home care at the same time. If you already have Medicaid, you just ask for "immediate need" home care.

You can apply whether you are home, in a hospital, or nursing home.

In New York City, submit the following documents in person, by mail or fax to:

HRA--HCSP Central Medicaid Unit FAX - 1-917-639-0665
785 Atlantic Avenue, 7th Floor
Brooklyn, NY 11238

What To Submit:

1. **HRA HCSP Transmittal Form HCSP -3052 –** Cover form in NYC only

2. **Medicaid application** with all required documents. This must include "Supplement A" (DOH-5178A outside NYC)(DOH-4495A in NYC) (alternate languages and formats of forms posted at this link). See more about Medicaid eligibility here.
    1. If you already have Medicaid, no new application needed. Submit the approval notice and CIN number.
    2. If an application was submitted and is pending, submit a copy along with all documentation, and proof of when and where it was filed.

3. **Physician's order/ Form outside NYC -** Form DOH-4359, (Form M11q in NYC) - Must be current, meaning that your doctor saw you and signed the form less than 30 days before you submit it. See **Q-Tips**. Doctor may attach extra comments.
4. **Attestation of Immediate Need (OHIP 0103) --** Consumer must sign this form to attest to immediate need. Form is attached. You have an immediate need even if your family has been providing some assistance, if that assistance is not enough or cannot continue. Explain the particular facts in a COVER LETTER.
5. **Married applicants** whose spouse does not need or receive Medicaid can request **spousal impoverishment budgeting,** which allows the couple to keep about $3400 in combined income and $90,000 in combined assets (Spouse can keep about $75,000 and Applicant can keep $14,850)(Retirement funds such as IRAs do not count if they are in distribution status). You may not need to use "Spousal Refusal" or a Pooled Income Trust with this budgeting. Use the DOH **"Request for Assessment" form** to request spousal impoverishment budgeting (page 9 of this link)
6. **HIPAA release** - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA
7. **If you are requesting Consumer Directed assistance,** include a completed application for CDPAP https://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/m_13d.pdf
8. **New: Pooled trust -** submit it with the application with all of the documents listed in http://www.wnylc.com/health/entry/44/). In cover letter, request that you be initially budgeted with a spend-down, until the trust is approved, so that home care can be initiated, subject to a spend-down.

   NOTE: This is a change from our previous view, which counseled to delay submitting a trust until after the Medicaid application was approved, because the trust could cause delays. Pooled trusts submitted with a Medicaid application should both be approved within 90 days. 42 C.F.R. Sec. 435.911. In NYC, HRA agreed to comply with this time limit in Garcia v Banks Settlement (SDNY 16-CV-08370, March 12, 2019). The 90-day time limit does not apply to a pooled trust submitted *after* the Medicaid application is submitted, which is why it is recommended to submit them together. For problems with delays in approving pooled trusts submitted with Medicaid applications email Aytan.Bellin@bellinlaw.com.

9. **Cover letter** that explains:
   - why you have an "immediate need" for services, (con'd)

- gives contact info for a family member or friend to arrange home visits for assessment and explains who will be "directing" care if the applicant has dementia,
- requests "spousal impoverishment" budgeting if helpful for married applicant, and or "spousal refusal" if needed regarding resources.
- if you are requesting CDPAP, explain your plan for arranging care
- if you are submitting a pooled trust, request that you be initially budgeted with a spend-down, until the trust is approved.

What Happens After I Submit the Application Package?

In the next **12 days,** the Medicaid office should process your Medicaid application, send a nurse to your home to assess your need for home care, and authorize you for personal care or CDPAP services provided by an agency that contracts with NYC or your local DSS. They may ask you to provide some additional documents.

After the home care services are provided for 120 days, you will receive a notice from New York Medicaid Choice, a state contractor that serves as the enrollment broker for all managed care programs. The notice will explain that you need to select and enroll in an Managed Long Term Care (MLTC) plan within 60 days If you do not select one, you will be auto-assigned to one.

Transition Rights in MLTC plan. As long as you wait to enroll in an MLTC plan after receiving this notice from NY Medicaid Choice, the new MLTC plan must give you the same plan of care (hours of home care) that you received from DSS/HRA for 90 days. This is called "Transition Rights." See MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care. DO NOT ENROLL IN AN MLTC PLAN before you receive the letter from NY Medicaid Choice! If you do, the MLTC plan may deny you "Transition Rights" – and not give you the same hours of service that you received from DSS/HRA.

After the 90-day transition period, the MLTC plan may only reduce your hours if your condition has improved or your circumstances have changed, so that you need less care. Notice must be provided with appeal rights. See MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services.*

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For more info see https://www.health.ny.gov/health_care/medicaid/#need_and http://www.wnylc.com/health/entry/203/

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IMMEDIATE NEED FOR PERSONAL CARE SERVICES/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES: INFORMATIONAL NOTICE AND ATTESTATION FORM

If you think you have an immediate need for Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS), such as housekeeping, meal preparation, bathing, or toileting, your eligibility for these services may be processed more quickly if you meet the following conditions:

- You have no informal caregivers available, able and willing to provide or continue to provide care;
- You are not receiving needed help from a home care services agency;
- You have no adaptive or specialized equipment or supplies in use to meet your needs; and
- You have no third party insurance or Medicare benefits available to pay for needed help.

If you don't already have Medicaid coverage, and you meet the above conditions, you may ask to have your Medicaid application processed more quickly by sending in: a completed Access NY Health Insurance Application (DOH-4220); the Access NY Supplement A (DOH-4495A or DOH-5178A), if needed; a physician's order for services; and a signed *"Attestation of Immediate Need."

If you already have Medicaid coverage that does not include coverage for community-based long term care services, you must send in a completed Access NY Supplement A (DOH-4495A or DOH-5178A), a physician's order for services and a signed *"Attestation of Immediate Need."

If you already have Medicaid coverage that includes coverage for community-based long term care services, you must send in a physician's order for services and a signed *"Attestation of Immediate Need."

If you don't already have Medicaid coverage or you have Medicaid coverage that does not include coverage for community-based long term care services: All of the required forms (see the appropriate list, above) must be sent in to your local social services office or, if you live in NYC, to the Human Resources Administration (HRA). As soon as possible after receiving all of these forms, the social services office/HRA will then check to make sure that you have sent in all the information necessary to determine your Medicaid eligibility. If more information is needed, they must send you a letter, by no later than four days after receiving these required forms, to request the missing information. This letter will tell you what documents or information you need to send in and the date by which you must send it. By no later than 7 days after the social service office/HRA receives the necessary information, they must let you know if you are eligible for Medicaid. By no later than 12 days after receiving all the necessary information, the social services office/HRA will also determine whether you could get PCS or CDPAS if you are found eligible for Medicaid. You cannot get this home care from Medicaid unless you are found eligible for Medicaid. If you are found eligible for Medicaid and PCS or CDPAS, the social services office/HRA will let you know and you will get the home care as quickly as possible.

If you already have Medicaid coverage that includes coverage for community-based long term care services: The physician's order and the signed Attestation of Immediate Need must be sent to your local social services office or HRA. By no later than 12 days after receiving these required forms, the social services office/HRA will determine whether you can get PCS or CDPAS. If you are found eligible for PCS or CDPAS, the social services official/HRA will let you know and you will get the home care as quickly as possible.

The necessary forms may be obtained from your local department of social services or are available to be printed from the Department of Health's website at: http://www.health.ny.gov/health_care/medicaid/#apply

*Found on the back side of this page.

Attestation of Immediate Need
for
Personal Care Services/Consumer Directed Personal Assistance Services

I, _____ attest that I am in need of immediate Personal Care Services
(Name)
or Consumer Directed Personal Assistance Services.

I also attest that:

- no voluntary informal caregivers are available, able and willing to provide or continue to provide needed assistance to me;
- no home care services agency is providing needed assistance to me;
- adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers or wheelchairs, are not in use to meet, or cannot meet, my need for assistance; and
- third party insurance or Medicare benefits are not available to pay for needed assistance.

I certify that the information on this form is correct and complete to the best of my knowledge.

X _____ _____
SIGNATURE OF APPLICANT/ REPRESENTATIVE **DATE SIGNED**

Individuals Receiving Long Term Care Services
in a Nursing Home or Hospital Setting

If you are receiving long term care services in a nursing home or a hospital setting and intend to return home, you may have your eligibility for Personal Care Services or Consumer Directed Personal Assistance Services processed more quickly. Follow the directions on the previous page and fill in the information requested below.

I am in a nursing home or a hospital setting and have a date set to return home on _____.
DATE

Contact me or my legal representative by calling _____.

IMMEDIATE NEED TRANSMITTAL TO THE HOME CARE SERVICES PROGRAM

NYC Human Resources Administration
Department of Social Services

HCSP-3052 (E) 09/19/2016

DATE: _____ CONSUMER'S NAME:_____ LAST 4 DIGITS OF CONSUMER'S SSN: _____

From
NAME OF SUBMIITING ORGANIZATION
STREET ADDRESS
CITY, STATE, ZIP CODE

To:
HOME CARE SERVICES PROGRAM – IMMEDIATE NEEDS
785 ATLANTIC AVENUE, 7th Floor
BROOKLYN, NY 11238

I am submitting this application package on behalf of the above named consumer for processing as an "Immediate Need" for home care services. S/he wishes to be enrolled in the following program (check one):

☐ Personal Care (PCS) ☐ Consumer Directed Personal Assistance (CDPAS)

I understand that the documentation listed in the table(s) below is **required** for this request to be processed. All are attached and appear to be fully completed.

For **all** Immediate Need Requests

OHIP-0103, **Attestation of Immediate Need**	HCSP M-11q, **Medical Request for Home Care**	OCA-960, **Authorization for Release of Health Information Pursuant to HIPAA**

Also required, in addition to the three items listed above, **if** the consumer already has Medicaid coverage, but it does not include long term care coverage

DOH-4495A, **Access NY Supplement A**	All necessary proofs that apply to this supplemental form **only**, as detailed in the DOH-4220 "**Documents Needed When You Apply For Public Health Insurance**" section

Also, required in addition to everything listed in both tables above, **if** the consumer does not already have Medicaid coverage at all

DOH-4220, **Access NY Insurance Application**	All necessary proofs as detailed in the DOH-4220 "**Documents Needed When You Apply For Public Health Insurance**" section

Though not required, I understand that submission of a cover letter that includes an explanation of the immediate need, the status of consumer's current whereabouts, a listing of submitted documents, the type of service requested (PCS or CDPAS), is strongly recommended.

☐ I have attached a cover letter ☐ I have not submitted a cover letter

Print Name:	Sign Name:	Telephone Number:

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
County DSS or NYC HRA

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here _____ (Initials) I authorize COUNTY DSS or NYC HRA (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	5 years from date signed
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

SAMPLE COVER LETTER – IMMEDIATE NEED WITH MEDICAID APPLICATION

DATE

By Hand or by e-Fax: 917-639-0665

Human Resources Administration
HCSP Central Medicaid Unit - IMMEDIATE NEED PROCESSING
785 Atlantic Avenue, 7th Floor
Brooklyn, NY 11238

RE: Medicaid Application for IMMEDIATE NEED PERSONAL CARE SERVICES
NAME -- DOB
SSN Last 4 digits xxxx
address

To Whom It May Concern:

Enclosed please find an initial, complete application for the above-named Applicant for Community Medicaid with Community Based Long Term Care Coverage. Because the Applicant has a medical need for Personal Care Services to start immediately, a signed Medical Request for Home Care/ Physician's Order for Personal Care Services (hereafter "M11q") is also attached, along with the Attestation of Immediate Need.

The applicant, age [ ], needs.. **For these reasons applicant requests assistance during a xx-hour span of time xx days/week.**

OTHER HOME CARE [why CHHA or other care is insufficient]

The applicant has no informal caregivers able and willing to provide assistance with personal care services. [EXPLAIN]

This applicant would be at risk if forced to wait until she can enroll in a Managed Long Term Care plan, which would take an estimated three months or more -- 45 days for processing the application, 1-2 weeks for the conflict-free assessment, another 1-2 weeks for an MLTC plan to assess and enroll her, and then a delay until enrollment begins the 1st of the of the next month or often the second following month.

Given this immediate need:

1. We ask HRA HCSP to process this application pursuant to the **Immediate Need** directives, NYS DOH OHIP ADM 16 ADM-02 - Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services, and the NYC HRA MICSA Alert dated Oct. 19, 2016.
2. [IF MARRIED AND NEED --] We ask for **Spousal Impoverishment protections** to be used, which the applicant is entitled to under 16 ADM-2. If this budgeting is used, the applicant should have no spend-down. [Option to include budget computation]

MMMNA (2020)	$3,216	Minimum Monthly Maintenance Needs Allowance
Spouse Income	- $1,000	(spouse not receiving Medicaid)
CSIA (2020)	$2,216	Community Spouse Income Allowance
Applicant Income	- 2,000	

Applicant's income is < CSIA. Therefore none of Applicant's income is countable. Spenddown is ZERO.

3. [IF IN NURSING HOME Please conduct the requisite **assessments at NURSING HOME address** Contact xxx, social worker, TEL]
4. In order to arrange a **home visit** if necessary, while applicant is still in rehab facility, please contact [son NAME PHONE]

Thank you for your prompt processing of this Medicaid application and Request for Home Care.

Sincerely,

NAME
Direct
TITLE
ORGANIZATION
Direct Dial
Fax
E-mail

Enclosures:

1. HRA Immediate Need Transmittal Form (HSCSP-3052)
2. Medical Request for Home Care- Form HCSP-M11Q, signed xxx
3. Attestation of Immediate Need, signed xxxx
4. HIPPA – Form OCA-960
5. [Power of Attorney if HIPPA signed with POA]
6. Medicaid Application- Form DOH-4220
7. Supplement A- Form DOH-4495A
8. Medicare card –applicant
9. Passport - applicant
10. Proof of address
11. Proof of income – Required Minimum Distributions (Social Security income shown in bank statements)
12. Proof of resources –most recent bank statement