NEW YORK STATE
OFFICE OF TEMPORARY AND
DISABILITY ASSISTANCE

RECERTIFICATION FOR MEDICAL
ASSISTANCE (Chronic Care)

DIRECTIONS

1. Please Print Clearly.
   Do Not Write in the Shaded Areas.
2. Fill out the form completely and accurately.
3. Sign the Form on the Back Page.
4. Return this recertification to the address listed.

LOCAL DISTRICT NAME AND ADDRESS _____

RECIPIENT'S INFORMATION

FIRST NAME _____
M.I. _____
LAST NAME _____
DATE OF BIRTH
  Mo _____
  Day _____
  Yr. _____
SEX
  ☐ MALE
  ☐ FEMALE
SOCIAL SECURITY NUMBER _____
LIST MAIDEN/OTHER NAMES RECIPIENT HAS BEEN KNOWN BY _____
NAME AND ADDRESS OF RECIPIENT'S FACILITY _____

RECIPIENT'S SPOUSE'S INFORMATION

SPOUSE'S FIRST NAME ___
M.I. _____
SPOUSE'S LAST NAME _____
DATE OF BIRTH
    Mo _____
    Day _____
    Yr. _____
IF SPOUSE IS DECEASED ✓ HERE □
IS SPOUSE APPLYING/RECERTIFYING/RECEIVING?
    □ YES
    □ NO
SPOUSE'S SOCIAL SECURITY NUMBER _____
SPOUSE'S ADDRESS _____
SPOUSE'S PHONE NUMBER Area Code ( ) _____
LIST ANY OTHER/MAIDEN NAMES BY WHICH YOUR SPOUSE HAS BEEN KNOWN. _____
LIST ANY DEPENDENT FAMILY MEMBER WHO IS LIVING WITH YOUR SPOUSE. _____
LIST ANY FAMILY MEMBER'S RELATIONSHIP TO YOU OR YOUR SPOUSE. _____
FAMILY MEMBER'S DATE OF BIRTH
    Mo _____
    Day _____
    Yr. _____
PERSON'S PHONE NUMBER Area Code ( ) _____
RESOURCES

LIST ANY RESOURCES THAT THE RECIPIENT MAY HAVE:

Personal Incidental Account (PIA)

☐ YES
☐ NO
$ VALUE _____
ACCOUNT NUMBER _____
LOCATION _____

Savings Account (Checking/Savings/Certificate of Deposit in Bank, Credit Union)

☐ YES
☐ NO
$ VALUE _____
ACCOUNT NUMBER _____
LOCATION ____

☐ YES
☐ NO

$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

☐ YES
☐ NO

$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Expect Lawsuit Settlement, Inheritance
☑ YES
☑ NO

$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Trust Fund
☑ YES
☑ NO

$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Life Insurance
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Annuity
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Stocks, Bonds, Savings Bonds
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Real Estate (Including Vacation Property and Homestead)
Income-Producing Property
Non-Income-Producing Property
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Own Home
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Mutual Fund
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

IRA, KEOGH, 401-K, Deferred Comp.
☐ YES
☐ NO
$ VALUE ____
ACCOUNT NUMBER ____
LOCATION ____

Other Pension or Retirement Account
☐ YES
☐ NO
Burial Fund, Burial Trust, Burial Space (Cemetery Plot), Funeral Agreement
☐ YES
☐ NO

Other Resources (Please Specify)
☐ YES
☐ NO

Motor Vehicle
☐ YES
☐ NO

HAVE YOU OR YOUR SPOUSE SOLD, GIVEN AWAY, OR TRANSFERRED ANY CASH, INCOME, REAL
ESTATE, OR OTHER ASSET WITHIN THE PAST 36 MONTHS (60 MONTHS FOR TRUSTS)?

☐ YES
☐ NO
ASSET ____
VALUE $ ____
WHO DID IT GO TO? ____

☐ YES
☐ NO
ASSET ____
VALUE $ ____
WHO DID IT GO TO? ____

☐ YES
☐ NO
ASSET ____
VALUE $ ____
WHO DID IT GO TO? ____
INCOME

LIST ANY INCOME THAT THE RECIPIENT, RECIPIENT'S SPOUSE, OR DEPENDENT FAMILY MEMBER, MAY HAVE:

Social Security/Railroad Retirement

RECIPIENT'S INCOME
☐ YES
☐ NO
AMOUNT _____

SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT _____

FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT _____

Pension

RECIPIENT'S INCOME
☐ YES
☐ NO
AMOUNT _____
SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT _____
FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT _____
Veteran's Pension
RECIPIENT'S INCOME
☐ YES
☐ NO
AMOUNT _____
SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT _____
FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT _____
IRA, KEOGH, 401-K, Deferred Compensation
RECIPIENT'S INCOME
☐ YES
☐ NO
AMOUNT _____
SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT _____
FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT _____
Alimony/Spousal Payment
RECIPIENT'S INCOME
☐ YES
☐ NO
AMOUNT _____
SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT _____
FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT _____
Mortgage/Rental Income
RECIPIENT'S INCOME
☐ YES
☐ NO
□ NO
AMOUNT ____
SPOUSE'S INCOME
□ YES
□ NO
AMOUNT ____
FAMILY MEMBER'S INCOME
□ YES
□ NO
AMOUNT ____

Dividends from Stocks, Bonds, Mutual Funds
RECIPIENT'S INCOME
□ YES
□ NO
AMOUNT ____

SPOUSE'S INCOME
□ YES
□ NO
AMOUNT ____
FAMILY MEMBER'S INCOME
□ YES
□ NO
AMOUNT ____

Other Income such as Disability Benefits, SSI, Employment, etc. *(Please Specify)*
RECIPIENT'S INCOME
☐ YES
☐ NO
AMOUNT _____

SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT _____

FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT _____

Do you expect to receive income from a trust, Lawsuit Settlement, Inheritance, etc.?

RECIPIENT'S INCOME
☐ YES
☐ NO
AMOUNT _____

SPOUSE'S INCOME
☐ YES
☐ NO
AMOUNT _____

FAMILY MEMBER'S INCOME
☐ YES
☐ NO
AMOUNT _____
HEALTH INSURANCE

Does the Recipient Have Medicare (Red, White and Blue Card).
☐ Yes
☐ No
If Yes,
☐ Part A
☐ Part B

Does the Recipient's Spouse or Dependent Family Member have Medicare?
☐ Yes
☐ No
If Yes,
☐ Part A
☐ Part B

Are you, Your Spouse or a Dependent Family Member covered under any Health Insurance Plan, such as Plans provided by Employer, Unions, Retirement System; Coverage under Support Order, Private Insurance Plans or VA (Aid and Attendance)?
☐ Yes
☐ No
Name of Covered Person(s) ____
Who Pays the Premium ____
Name of Insurance Company ____
Policy Number ____
Who Does the Policy Cover? ____
Effective Date of Policy ____
Amount of Premium and how often paid? ____

HOUSING EXPENSES

Does Your Spouse have a Housing Expense? If Yes, Fill in the Requested Information.

☐ Yes
☐ No

MONTHLY RENT AMOUNT $ ____
MONTHLY MORTGAGE AMOUNT $ ____
MONTHLY TAX AMOUNT $ ____
MONTHLY HEAT BILL $ ____

RACE/ETHNIC AFFILIATION FOR APPLICANT ONLY

(Completion is optional. However, if not completed, the interviewer may have to record it by observation. This information is being collected only to be sure that everyone receives assistance/care on a fair basis. This
information will not affect your eligibility.) I am: (Check Only One)

B ☐ Black not of Hispanic origin
W ☐ White not of Hispanic origin
I ☐ American Indian or Alaskan Native
H ☐ Hispanic
A ☐ Asian or Pacific Islander

NON-DISCRIMINATION NOTICE—This application will be considered without regard to race, color, sex, handicaps, religious creed, national creed, national origin or political beliefs.

SOCIAL SECURITY NUMBER—A person making application for Medical Assistance (MA) shall disclose the Social Security Number of any person for whom Medical Assistance is requested, except when the individual is an undocumented alien seeking MA-only for the treatment of an emergency medical condition. Such disclosure is mandatory for Medical Assistance under the authority of Sections 351.2 and 360-1.2 of 18NYCRR and 42 USC
1320b-7. Social Security Numbers are used to provide proper identification of applicants for and recipients of Medical Assistance and to verify income, eligibility and benefits amounts. We will also be using your Social Security Number to match with IRS unearned income data and with the New York State Department of Labor for earned income data.

**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 Medical Assistance. If additional information is requested, I will provide it.

**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.

**ASSIGNMENT OF INSURANCE AND OTHER BENEFITS**—I will file any claims for health or accident insurance benefits or any other resources to which I am entitled, and do hereby assign any such resources to the Social Services official to whom this application is made. In addition, I will assist in making any required assignment...
of benefits or resources to the Social Services official to whom this application is made.

**DIRECT PAYMENT**—I authorize the payment to me or members of my household for health or accident insurance benefits be made directly to the appropriate Social Services official for medical and other health services furnished while we are eligible for Medical Assistance.

**MEDICARE**—I authorize payments under "Medicare" (Part B of Title XVIII, Supplementary Medical Insurance Program) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medical Assistance.

**PENALTIES**—I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State Law provide for penalties of fine, imprisonment of both if you do not tell the truth when you apply for Medical Assistance 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 Medical Assistance or if
you conceal or fail to disclose facts that would affect the right of someone for whom you have applied to obtain or continue to receive Medical Assistance benefits; and such benefits must be used for that other person and not for yourself.

Federal and State Law provide that any transfer of an asset for less than fair market value made by an individual or his/her spouse within or after the thirty-six months (sixty months for transfers to trusts) immediately preceding the first day of the month in which the individual becomes institutionalized, or the date of application for Medical Assistance as an institutionalized person, if later, may render the individual ineligible for nursing facility services.

**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 Medical Assistance 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 I may be required, as a condition of eligibility for Medical Assistance, to assign to the Department of Social Services the proceeds of the sale of my excess resources. I understand that upon receipt of Medical Assistance, a lien may be filed and a recovery may be made against my real
property under certain circumstances if I am in a medical institution and not expected to return home. I understand that Medical Assistance paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

RECIPIENT'S SIGNATURE ____
   DATE SIGNED ____
SPOUSE'S SIGNATURE ____
   DATE SIGNED ____
REPRESENTATIVE'S SIGNATURE ____
   DATE SIGNED ____
WORKER'S SIGNATURE ____
   DATE SIGNED ____