ALBANY CO DSS
100 FIRST ST
40 HOWARD ST
ALBANY, NY 12202

NOTICE OF RECERTIFICATION FOR MEDICAL ASSISTANCE.

SE LE ENVIARA UNA COPIA EN ESPANOL DE ESTA NOTIFICACION EN UN SOBRE APARTE

NOTICE NUMBER:	DATE:	CASE NUMBER:
U0102C4984	June 20, 2013	TST307SMW

OFFICE	UNIT	WORKER	UNIT OR WORKER NAME	TELEPHONE NO.
Z61	TEST	FONT	DEFAULT MA	518-474-9440

AGENCY TELEPHONE NUMBERS

GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP	518-473-1000
OR Agency Conference	518-473-1000
Fair Hearing information and assistance	518-473-1000
Record Access	518-473-1000
Child/Teen Health Plan	518-473-1000

CASE NAME / AND ADDRESS

Z61/TEST/FONT

HAYNER, MATTHEW
307 WEST ST,
ALBANY, NY 12345

MEDICAL ASSISTANCE

MEDICAID, FAMILY HEALTH PLUS, FAMILY PLANNING BENEFIT PROGRAM RENEWAL FORM

- It is time to renew your health insurance benefits.
- You must answer **all** the questions and return this form and any required documentation to the following address by **Tuesday, September 24, 2013.**

ABC OFFICE NAME FOR TESTING, ABC FIRST LINE ADDRESS FOR TESTING, ABC SECOND LINE ADDRESS FOR TESTING, ABC CITY TESTIN NY 10009

- If you do not complete and return this form, you will lose your health insurance. If we are paying your Medicare premium or other health insurance premium, we will also stop making these payments.
- You must return this form even if you have told us you moved to another county.
- This form is not complete until you sign and date it.
- Please read the Terms, Rights, and Responsibilities.

CONTINUED ON THE NEXT PAGE ...

****
* Important Instructions-Please Read this Page *
****

- To determine your eligibility, the amount of income you report will be compared to available computer matches. In some cases, the data from the computer match may change your coverage from Medicaid to Family Health Plus.
- **You do not need to send proof of income at this time unless the renewal form says you must.**
- **However, since the amount you report may not match the amount found in the computer matches, you may wish to submit proof of your income to be sure that you receive the correct coverage.**
- You may be asked to provide proof of your income at a later date. If needed, you will be contacted and told what to send in. The enclosed "Documentation Checklist" shows you the things you can use as proof of these items.

You may call the social services office for help with this form. There are also community organizations and health plans that can help you. You can **call 1-877-934-7587** or **1-800-698-4543** to find a health plan or community organization in your area that provides assistance. If you go to one of these organizations for help, bring this letter with you. You must still return the form and documentation to the address above by the date shown. You may wish to keep a copy of this form for your records.

MAKE SURE YOU ANSWER EVERY QUESTION AND SIGN THE FORM. RETURN ALL PAGES AND ANY REQUIRED DOCUMENTATION BY MAIL OR IN PERSON TO THE SOCIAL SERVICES OFFICE. YOU DO NOT NEED TO COME IN FOR AN INTERVIEW.

CONTINUED ON THE NEXT PAGE ...

CASE NUMBER: TST307SMW CASE NAME: HAYNER, MATTHEW

RENEWAL FOR MEDICAID - FAMILY HEALTH PLUS -FAMILY PLANNING BENEFIT PROGRAM

1. You last reported you live at:
   307 WEST ST
   ALBANY, NY 12345

   Is this still where you live?

   [__] Yes
   [__] No. I live at:

   House# Street Apt. #

   City State Zip

   Send proof of your new address.

   [__] Check here if homeless.

   If you do not receive mail where you live, please write your mailing address below:

   House # Street Apt. # PO Box#

   City State Zip

   My telephone number is: _____
   [_] Home [_] Cell [_] Work [_] Other

   Another phone number where I can be reached is: _____
   [_] Home [_] Cell [_] Work [_] Other

2. You are renewing health care coverage for the following persons. **(Make any corrections to name or date of birth below.)** If a Social Security Number (SSN) is listed as "not on file", write it in the space below. If this person does not have a SSN leave this space blank. If the following persons are found to be not otherwise eligible for Medicaid or Family Health Plus, please check the box in the last column if they are interested in receiving coverage from the Family Planning Benefit Program (FPBP).

Name	Date of Birth	SSN (If you have one)	Still living with you?	FPBP
MARK HAYNER	6/15/1996	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
HELEN MOYER	8/15/1973	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
MARTY MOYER	3/14/1970	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
MARK MOYER	5/12/1997	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
MOLLY MOYER	4/18/1993	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		
MADISON MOYER	9/15/2003	ON FILE	_yes _no	[_]
_____	___/___/_____	___-___-_____		

CONTINUED ON THE NEXT PAGE ...

3. Who else lives with you? Write the full legal name(s) below and the relationship to the person listed first in question 2. (For example, spouse, parent/step-parent, child and their date of birth and gender.)

   o If anyone listed below wants to apply for health insurance, write their social security number below.

Name	Relationship	Date of Birth	Gender (M/F)	SSN (If you have one)	Does this person want health insurance?
_____	_____	_____	___	_____	___Yes ___No
_____	_____	_____	___	_____	___Yes ___No
_____	_____	_____	___	_____	___Yes ___No
_____	_____	_____	___	_____	___Yes ___No

   o Identity and U. S. citizenship or satisfactory immigration status must be documented. If anyone listed above who is applying for health insurance is declaring to be a U. S. citizen or national and provides his or her SSN or proof that an SSN was applied for, Medicaid will verify his or her SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, proof of identity and U. S. citizenship status may be required.

   o Anyone listed above who is applying for health insurance and is not a U.S. citizen must **send proof** of identity and immigration status.

   o Proof of income is also required

   o Include anyone applying for health insurance when you answer the rest of the questions on this form.

   Note: Only certain family members can apply using this form. We will contact you if we need a different form.

4. Is anyone listed in questions 2 or 3, pregnant?
   [__] No.
   [__] Yes. Who? _____ Expected due date: _____

   If yes, you **must send proof** of due date. See documentation checklist.

CONTINUED ON THE NEXT PAGE ...

5. NEW OR CHANGED HEALTH INSURANCE SINCE YOU LAST APPLIED OR RENEWED:

a. Has anyone who had health insurance coverage **lost** the coverage?
[__] No.

[__] Yes. Who? Insurance company name: Date Coverage Ended:

_____ _____ _____

b. Has anyone **started** being covered by health insurance (including Medicare or long-term care insurance) other than Medicaid/Family Health Plus? We may be able to pay the cost of your health insurance premiums if it is cost effective.
[__] No.

[__] Yes. Name of Insured Premium amount: Paid How Often:

_____ $_____ _____

You must send a copy of the front and back of the insurance card and/or Medicare card (red, white and blue card) for each person and a copy of the insurance policy.

c. If you are not insured through your job now, does your job offer health insurance? We may be able to pay the cost of your health insurance premiums if it is cost effective.
[__] No.

[__] Yes.

If yes, list employer name, address, and telephone number below:

_____
_____
_____
_____

6. ILLNESS, INJURY OR DISABILITY

a. Since you last applied/renewed, has anyone become blind, or disabled, or does anyone now have a chronic illness or special health care need? 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.

[__] No [__] Yes If yes, who?

_____

Explain: _____
_____

b. If you are blind or disabled do you pay special expenses (non-medical) in order to work?
[__] No [__] Yes **(You must send in receipts for these expenses.)**

c. Does anyone who is renewing or applying have a pending lawsuit due to an injury?
[__] No [__] Yes

If yes, who? _____

d. Does anyone renewing or 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? _____

CONTINUED ON THE NEXT PAGE ...

7. If there is a parent or spouse living outside of the home, please answer the following questions.

A. Since you last applied/renewed, has the spouse or parent of someone renewing moved out of the home?

[__] No (Go to Question B.)

[__] Yes. Give the following information, if known.
Name: Parent_____Spouse _____
Date of Birth _____ Social Security Number _____
Address _____
Parent/Spouse of _____

Note: Families who are renewing 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 a good cause.

[__] Check here if claiming good cause. I have a good reason you should not contact this parent/spouse (fear from a threat of physical or emotional harm). This is called "good cause". If you checked this box, you will be contacted to explain your reason and to provide proof.

B. Since you last applied/renewed, do you have any information that you have not previously given us to help us find a spouse or parent who does not live in the home (e.g., home address or work place)?

[__] No.
[__] Yes. **Give the following information, if known.**
Name: Parent_____Spouse _____
Home Address _____
Work Address _____
Parent/Spouse of _____

Name: Parent_____Spouse _____
Home Address _____
Work Address _____
Parent/Spouse of _____

CONTINUED ON THE NEXT PAGE ...

8. a. Write the types of income (money) and the amount received by everyone listed in Questions 2 and 3. See the documentation checklist for examples of income. **Write the amount before any taxes or other deductions; include tips/commissions. Send pay stubs or other proof.**

If you or anyone renewing or applying is self-employed, check here: [_]

Name	Type of Income/Source	Name of Employer (if income is from employment)	How Much (before taxes /deductions include tips/ commissions)	How Often Weekly/ 2 weeks/ Monthly
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____

Check the box if the statement applies to you:
[_] I do not get paychecks or pay stubs.
[_] I get paid in cash.

b. Do you or any adult in Question 2 or 3 have no income?
[_] No [_] Yes Who? _____

If there is no income listed above, please explain how you are living: (For example: living with friend or relative.)

_____

c. Have you or anyone who is applying changed jobs or stopped working in the last three months?
[_] No [_] Yes If yes, who? _____
If yes, last job was: Date: _____/___/___
Name of Employer:_____

d. Are you or anyone who is renewing or applying a student, in a vocational, undergraduate, or graduate program?
[_] No [_] Yes
If yes: [_] Full Time [_] Part Time [_] Undergraduate [_] Graduate
Student's name: _____

e. Do you or anyone who is renewing or applying pay for health insurance premiums, Medicare premiums, court ordered support, or child/adult care expenses?
[_] No [_] Yes If yes, fill out below and send proof of each expense.

Type of expense	Name of person paying the expense	How much is being paid	How often is the expense paid (Ex. Weekly, monthly)
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____
_____	_____	$ _____	_____

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.

Are you currently enrolled in the Medicaid Buy-In program for Working People with Disabilities, or applying for MBI-WPD?
[_] No [_] Yes
If YES, you must submit proof of your employment. See the enclosed Documentation Checklist for the documents you can use to prove you are employed.

If you are enrolled in the MBI-WPD program but are no longer working, please state the reason and the date you last worked.

CONTINUED ON THE NEXT PAGE ...

Reason no longer working:

_____

Date last worked: _____

9. Has your share of the monthly housing payment (such as rent or mortgage, including property taxes) changed since you last applied/renewed for your healthcare coverage?

[_] No
[_] Yes. My new share of the monthly housing payment is $_____

If you pay for water separately, how much do you pay? $_____ **Send proof** of water bill.

Do you receive free housing from your employer? [_] Yes [_] No

10. **Proof of identity, United States citizenship or satisfactory immigration status is a requirement for Medicaid eligibility.**

If you are declaring to be a U. S. citizen, but you have not provided proof of U. S. citizenship, provide your SSN or proof that an SSN was applied for, and Medicaid will verify your SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, proof of identity and U. S. citizenship status may be required. Proof of identity and citizenship requires original documents or copies certified by the issuing agency.

a. Has anyone renewing not provided proof of U.S. citizenship? Who? SSN (If you have one)

_____ _____
_____ _____
_____ _____

If you are an immigrant, but have not provided proof of your identity and immigration status, or if your immigration status has changed you must send us proof. Send proof from the federal immigration agency showing your current immigration status.

b. Has the immigration status of anyone renewing changed? Who? SSN (If you have one)

_____ _____
_____ _____
_____ _____

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11. RESOURCES

List all resources (resources include money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, or property that someone owns. Do not list your home).

If you do not have any resources, please write "NONE" under "Resource Type."

What are your current resources?

Resource Type	Value	Owner	Bank/Company Name
_____	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____
_____	$_____	_____	_____

Do you want to continue to receive Medicaid coverage for long-term care services, such as home care or personal care services? ____ Yes ____ No

If yes, you need to send proof of your current resources.

By signing this form, I understand that each person listed will be enrolled in the appropriate program, if eligible. I have also read and understand the Terms, Rights and Responsibilities on the following pages. I certify under penalty of perjury that everything on this application is the truth as best I know.

_____ _____

SIGNATURE of Applicant or Representative DATE

_____ _____

SIGNATURE of Other Applying Adult DATE

OFFICE USE ONLY

Worker Signature	Supervisor Signature	Case Disposition

CONTINUED ON THE NEXT PAGE ...

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The New York Medicaid program must tell you how we use, share, and protect your health information. The New York Medicaid program includes regular Medicaid, Medicaid Managed Care, and Family Health Plus. The program is administered by the New York State Department of Health and the Local Department of Social Services.

A copy of the Notice may be obtained at your local Department of Social Services. It is also available at:

http://www.health.state.ny.us/health_care/medicaid/publications/docs/inf/06inf-03att1.pdf

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CHILD TEEN HEALTH PROGRAM

How can I get help finding a health care provider for my child for regular checkups?

There is a Medicaid program for children from birth to age 21 called the Child/Teen Health Program (C/THP) which provides check-ups and follow-up care if problems are found. Children from birth to age 21 who have Medicaid, Medicaid Managed Care, and 19 and 20 year old young adults who have Family Health Plus, can take advantage of this benefit.

Children and young adults should see a doctor for regularly scheduled check-ups even if they are healthy. The C/THP recommends that children have 10 check-ups before the age of 3 and a check-up once a year after that. The C/THP helps establish a "medical home." A "medical home" is a situation in which each patient has an ongoing relationship with a physician who is responsible for the patient's health care needs and, when needed, arranges for care with other qualified physicians.

Depending on a child's age, the C/THP check-up includes:

- Health history
- Asthma assessment, diagnosis and treatment
- Dental screening
- Hearing and vision testing
- Complete physical exam
- Blood tests (such as sickle cell anemia)
- Immunizations
- Developmental/behavioral assessment
- Blood lead level lab test - Children who are 1 or 2 years old and children between 3 and 6 years old who have not had a blood lead level lab test will receive one.

Advice and answers to your health questions

There are no Medicaid co-pays for this benefit. The benefit also includes necessary services that might not normally be provided by the child's regular doctor or clinic. The medical provider will arrange for follow-up treatment for problems found during the check-up.

If you are enrolled in a managed care plan, the plan includes the C/THP. Speak to your plan representative about these services.

If you are not enrolled in a managed care plan and you live in upstate New York, call your local department of social services to help you find doctors, dentists, prenatal care, family planning, and other providers that accept Medicaid and help with transportation, if necessary.

If you live in NYC, call 1-888-692-8662 for help finding doctors, dentists, prenatal care, family planning, other providers that accept Medicaid and help with transportation, if necessary.

THE SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS and CHILDREN (WIC)

Are you pregnant? A new mother? Have a baby or young children?
WIC can help you help your family. WIC provides healthy foods, nutrition and health education, breastfeeding support and referrals to health and social services to New York families at no cost.

For the location of the nearest WIC clinic, call 1-800-522-5006.

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying to renew Medicaid or Family Health Plus.

I understand that I must provide the information needed to prove my eligibility for each program. I agree to immediately report any changes to the information on this form. If I am unable to get the information, I will tell the local department of social services. The local department of social services may be able to help in getting the information.

I understand that workers from the programs for which family members or I are renewing may check the information given by me on this form. 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.

I understand that Medicaid and Family Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that 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, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program.

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.

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS I certify under penalty of perjury, by signing my name on this form, 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. The term "satisfactory immigration status" means an immigration status that does not make the person ineligible for benefits. **Important Information:** The **federal immigration agency** has said that enrollment in Medicaid/Family Health Plus CANNOT affect a person's ability to get a permanent resident card (green card), become a citizen, sponsor a family member or travel in and out of the country (unless Medicaid is being used to pay for long term care services in a nursing home or mental health facility). **The State will not report any information on this application to the federal immigration agency.**

SOCIAL SECURITY NUMBER 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.

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 Primary Care Provider, 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; 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 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 may include HIV, mental health or alcohol and substance abuse information about me and members of my family, to the extent permitted by law. 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.

MEDICAID MANAGED CARE If I am adding a family member to a Medicaid case and I live in a county that requires Medicaid recipients to join a health plan, I understand that this family member will be enrolled in the same health plan as my family, unless he or she is exempt or excluded.

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.

I consent to sharing this information with any school-based health center that provides services to the applicant(s).

DOCUMENTATION CHECKLIST

This is a list of documents that the Medicaid Program accepts. Please review the enclosed "MEDICAID, FAMILY HEALTH PLUS AND/OR FAMILY PLANNING BENEFIT PROGRAM RENEWAL FORM" to determine what documents you need to provide in order to continue your health care coverage.

PROOF OF INCOME Anyone new applying for health insurance must send proof of current income. However, any recipient may choose to send proof of current income if they want to.

Earned Income from Employer	Current paycheck/stubs (~~4~~ four consecutive weeks) **or** letter from employer
Self-Employment Income	Current signed income tax return and all schedules **or** record of earnings and expenses
Rental/Roomer-Boarder Income	Letter from roomer, boarder, tenant **or** check stub
Unemployment Benefits	Award letter/certificate, monthly benefit statement, correspondence from the NYS Department of Labor, printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us), **or** copy of Direct Payment Card with printout
Private Pensions/Annuities	Statement from pension/annuity
Social Security	Award letter/certificate, annual benefit statement, **or** correspondence from Social Security Administration
Employment Based Sick Pay/Disability Income	Award letter/certificate, benefit check stub, **or** correspondence from source of income
Child Support/Alimony	Letter from person providing support, letter from court, child support/alimony check stub, copy of NY Eppicard with printout, copy of child support account information from www.newyorkchildsupport.com, **or** copy of bank statement showing direct deposit
Worker's Compensation	Award letter **or** check stub
Veteran's Benefits	Award letter, benefit check stub, **or** correspondence from Veterans Administration
Military Pay	Award letter **or** check stub
Interest/Dividends/Royalties	Current statement from bank, credit union, or financial institution, letter from broker, letter from agent, **or** 1099 or tax return (if no other documentation is available)
Support from other Family Members	Signed statement or letter from family member
Income from a trust	Trust document

PROOF OF EMPLOYMENT (Medicaid recipients currently enrolled in the Medicaid Buy-In program must provide documentation of employment.)

- Current paycheck/stub; **or**
- Detailed written statement from employer; **or**
- W-2 form; **or**
- Income tax return.

CHILD CARE / DEPENDENT CARE EXPENSES Anyone new applying for health insurance must send proof of this expense, if applicable.)

- Written statement from day care center or other child/adult care provider; **or**
- Canceled checks or reciepts that show your payments.

HEALTH INSURANCE PREMIUMS (Provide, if applicable.)

Letter from employer Premium statement Pay stub

PRIVATE OR EMPLOYER BASED HEALTH INSURANCE (Provide only if new or changed since you last applied/renewed)

- Insurance policy; **or**
- Premium statement; **or**
- Insurance Card; **or**
- Terminati on letter; **or**
- Medicare Card (Red, white and blue card).

PREGNANCY (Provide, if applicable.)

- Statement from medical professional (such as a doctor or nurse practitioner) with the expected date of delivery; **or**
- Presumptive Eligibility Screening Worksheet completed by a qualified provider that tells us the expected date of delivery; **or**
- WIC Medical Referral Form that tells us the expected date of delivery.

If you do not have proof of your pregnancy when you return this renewal form, please get it as soon as possible and send it to your worker.

SPECIAL WORK EXPENSES FOR BLIND/DISABLED

If you are blind or disabled and must pay special non-medical expenses in order to work, (for example, you need special equipment or transportation), send in receipts that show what the expenses are and who provides them.

CITIZENSHIP/IDENTITY

NOTE: Anyone new applying for health insurance must prove identity, but does not have to send proof of citizenship or immigration status if he/she is:

- Pregnant; **or**
- An undocumented immigrant applying for Medicaid 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).

Documents which Establish both Citizenship and Identity: Identity and U. S. citizenship or satisfactory immigration status must be documented if anyone new is applying for health insurance. If you are applying for health insurance and are declaring to be a U. S. citizen or national, if you provide your SSN or proof that an SSN was applied for, Medicaid will verify your SSN and birth information, including identity through an electronic match with the Social Security Administration's records. If the match is not successful, proof of identity and U. S. citizenship status may be required. All documents must be originals or copies certified by the issuing agency. For the purposes of qualifying as a United States citizen, the United States 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. **(If you provide one of the following, no other document is required for proof of citizenship/identity.)**

- U.S. passport book/card; **or**
- Certificate of Naturalization (N-550 or N-570); **or**
- Certificate of U.S. Citizenship (N-560 or N-561); **or**
- NYS Enhanced Driver's License (EDL); **or**
- Native American Tribal Document, Certificate of Degree of Indian blood or other Native American/Alaska native tribal document with photo.

Documents which Establish Citizenship but also require one identity document

- U.S. Birth Certificate
- Certification of birth issued by Department of State (FS-545 or DS-1350); **or**
- Report of Birth Abroad (FS-240); **or**
- U.S. Citizen ID Card (I-197 or I-179); **or**
- Religious/school records; **or**
- Military record of service showing U.S. place of birth; **or**
- Final adoption decree; **or**
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.

Documents which Establish Identity

- State driver's license or ID card with photo; **or**
- ID card issued by a Federal, State, or local government agency; **or**
- U.S. Military card or draft record or U.S. Coast Guard Merchant Mariner Card; **or**
- School ID card with a photo; **or**
- Verified school, nursery or daycare records (for children under 16); **or**
- Clinic, doctor or hospital records (for children under 16).

Current Immigrant Status must be provided for any new person applying or any person renewing whose status has changed in the past 12 months or you must prove that you are in a satisfactory immigration status.

Immigration Status/Identity

- I-551 Permanent Resident Card ("Green Card"); **or**
- I-766 Employment Authorization Card.

Immigration Status, but require an additional identity document

- I-94 Arrival/Departure Record; **or**
- USCIS Form I-797 Notice of Action; **or**
- Evidence of Continuous U.S. residence prior to January 1, 1972.

These lists are not all inclusive. If you do not have one of these documents, please contact your local department of social services for information on other documents that can be used.

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment.

To Register You Must:

- be a U.S. citizen;
- be 18 years old by December 31 of the year in which you file this form (note: You must be 18 years old by the date of the general, primary, or other election in which you want to vote.);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in jail or on parole for a felony conviction; and
- not claim the right to vote elsewhere.

Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

New York State Board of Elections, 40 Steuben Street,
Albany, New York 12207-2109
Telephone: 1-800-469-6872;
TDD/TTY users contact the New York State Relay at 711;
or visit our web site - www.elections.state.ny.us

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Verifying your identity

We will try to check your identity before Election Day, through the **DMV number (driver's license number or non-driver ID number)**, or the **last four digits of your social security number**, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to *Verifying your identity* above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. To vote in a primary election, you must be enrolled in one of these listed parties — Except the Independence Party, which permits non-enrolled voters to participate in certain primary elections.

NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

☐ **YES** (If you check yes, please complete VOTER REGISTRATION APPLICATION at bottom of page)
☐ NO because I choose not to register OR
☐ I am already registered at my current address OR
☐ I asked for and received a mail registration form.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

_____ ___/___/___
(Signature) (Date)

_____
(Please Print Name)

Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料：如果你有興趣索取本中文資料表格，請電 1 - 800 - 367-8683

한국어: 한국어 양식을 원하시면 1-800-367-8683 으로 전화하십시오.

VOTER REGISTRATION APPLICATION (instructions on back)

NVRA-05 (01/2011)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1	Are you a U. S. citizen? Yes ☐ No ☐ If you answered NO, do not complete this form.	2	Will you be 18 years old on or before election day? Yes ☐ No ☐ If you answered NO, do not complete this form unless you will be 18 by the end of the year.	**For Board use only!**
3	Last Name First Name Middle Initial Suffix			
4	Address where you live (do not give P.O. address) Apt. No. City/Town/Village Zip Code County			
5	Address where you get your mail (if different from above) P.O. Box, star route, etc. Post Office Zip Code			

6	Date of Birth	7	Sex (circle) M F	8	Home Tel. Number (optional)	9 ID Number—Check the applicable box and provide your number: ☐ New York DMV number __ __ __ __ __ __ __ __ __ If you do not have a New York DMV number, please provide: ☐ Last four digits of your Social Security Number __ __ __ __ ☐ I do not have a New York Driver's license number
10	The last year you voted	Your Address was (give house number, street and city)				
	In county/state	Under the Name (if different from your name now)				

11	**Choose a party** -- Check one box only ☐ Democratic Party ☐ Republican Party ☐ Conservative Party ☐ Working Families Party ☐ Independence Party ☐ Green Party ☐ Other (write in) _____ ☐ I do not wish to enroll in a party	12	**AFFIDAVIT:** I swear or affirm that • I am a citizen of the United States. • I will have lived in the county, city or village for at least 30 days before the election. • I will meet all requirements to register to vote in New York State. • This is my signature or mark on the line below. • The above information is true, I understand that if it is not true, I can be convicted and fined up to $5,000 and/or jailed for up to four years. → _____ (Signature or Mark in Ink) (Date)

(Optional) Register to donate your organs and tissues

Last Name_____
First Name_____
Middle Initial_____ Suffix_____
Address_____
Apt Number_____ Zip Code_____
City_____
Birth Date_____ Sex ☐ M ☐ F
Eye Color_____ Height___ Ft.___In.

By signing below, you certify that you are:

- 18 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to DOH for enrollment in the Registry;
- And authorizing DOH to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and hospitals upon your death.

DONATE LIFE New York State

_____
Sign Date

XL148F (06/11)