Form MGP-003 (12/00)

DMH/DSS
MEDICATION GRANT PROGRAM
Application for Assistance
Transmittal/Response Form

Attachment 2

TRANSMITTAL

To: _____ County/New York City DSS Date
(County Name)

From: _____ County/New York City DMH
(County Name)

Applicant Name: Last: _____

First: _____ Middle Initial: _____
(Complete if available)

Street or Box # _____

_____

City: _____

State: _____ Zip: _____ – _____ Date of Birth _____ _____ _____
Month Day Year

Check Box 1 or 2 as appropriate:

1. ☐ Attached is an application for (Check all appropriate boxes).
   - ☐ **Medicaid**
   - ☐ **Cash Assistance**
   - ☐ **Food Stamps**

   Per our agreement, the filing date of this application is _____/_____/_____, the date the application was received
   Month Day Year

   by _____ DMH.
   (County Name)

2. ☐ An application for the following was submitted to the Department of Social Services

   on _____ _____ _____ *(Check all appropriate boxes.)*:
   Month Day Year

   - ☐ **Medicaid**
   - ☐ **Cash Assistance**
   - ☐ **Food Stamps**

Please advise _____ DMH of the decision on the Medicaid Application.
(County Name)

DMH Contact Person:	Telephone #:	Fax #:

RESPONSE

To: _____ County/New York City DMH
(County Name)

From: _____ County/New York City DSS
(County Name)

☐ Medicaid Application Approved: ☐ Medicaid Application Denied:

Begin Date: _____ _____ _____ MA ID# (CIN): _____ MA Denial Code: _____
Month Day Year

County DSS Contact Person:	Telephone #:	Fax #:

See instructions on back

Instructions for Completion of MGP 003

Purpose: To transmit the common application for Medicaid (Cash Assistance and Food Stamps) from County DMH to County DSS for the purpose of protecting the Medicaid filing date for enrollees in the Medication Grant Program (MGP). It can also be used to notify County DSS of an MPG enrollee when a Medicaid application has already been filed.

1. County DMH or designee completes the top of the Transmittal MGP 003 for the enrollee. DMH then checks box 1 or 2 as appropriate and completes the required information under that box.

2. County DMH sends the **white and yellow** copies to County DSS and keeps the **pink** copy for their record and/or follow-up.

3. County DSS holds the MGP 003 until Medicaid eligibility is determined. When the Medicaid application is approved or denied, County DSS completes the Response portion of the MGP 003 as appropriate and returns the **white** copy to County DMH. County DSS keeps the **yellow** copy for their records.