

MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding between \_\_\_\_\_ County Department of Social Services (DSS) and \_\_\_\_\_ County Department of Mental Hygiene (DMH) who service \_\_\_\_\_ County residents through the Medication Grant Program in which County Mental Hygiene staff accept the common application for Medicaid, Public Assistance, and Food Stamps.

WHEREAS, Kendra's Law provides access to medication and services for individuals who require medication to treat mental illness upon being released from State and local correctional facilities, or discharged from hospitals operated or licensed by the New York State Office of Mental Health;

WHEREAS, Kendra's Law requires that applications for Medicaid be expedited for persons receiving such medication and services and the parties agree that the application process can be expedited by DMH accepting applications on behalf of DSS for Medicaid, Public Assistance, and Food Stamps from such persons;

The parties agree as follows:

A. The DSS agrees to:

1. Work with the DMH to develop protocols for the receipt and processing of applications. This includes developing processes for notifying the DMH and the applicant of any requirement for additional documentation and of the final eligibility determination. Such procedure must allow for the submission of the DSS-2921 by the DMH and may allow for DMH or official designee to conduct the face to face interview.
2. Provide the designated DMH staff with the application package, including the DSS-2921, "How to Complete the Social Services Application," client booklets, DSS-2642 "Documentation Requirements," the Applicant Release Agreement, and any other required information.
3. Consider the application filing date for Medicaid, Public Assistance, and Food Stamps as the date the signed, completed application is received by the DMH.
4. Provide prompt feedback to the DMH on incomplete or incorrect applications so that problems can be addressed in a timely fashion.
5. Pend an application for Medicaid, Public Assistance, and Food Stamps filed by an applicant who is currently institutionalized but who is within 45 days of release.

6. Follow existing mandates for addressing Immediate Needs and Expedited Food Stamps for those applicants who are in the community or institutionalized and expected to qualify on release.
  7. Complete a separate Medicaid determination if Public Assistance is denied and inform the DMH of the Medicaid decision.
  8. Provide the DMH with the name(s), phone number, and, if available, fax number of a contact person at DSS.
- B. For the purpose of this program, the DMH agrees to:
1. Designate person(s) to interview applicants who potentially are eligible for the Medication Grant Program. These individuals, who will be residing in or recently released from psychiatric hospitals or wards or jails or prisons, are in need of medications to treat mental illness.
  2. Notify the DSS in writing of the name(s), title(s) and telephone numbers of the DMH staff who will be accepting applications.
  3. Retain documentation of the name, title, and telephone number of staff assisting individuals to complete applications.
  4. Obtain a signed DSS Release of Information form from the applicant when appropriate, e.g. to obtain medical information needed for a disability determination, and obtain a signed Applicant Release Agreement prior to obtaining confidential applicant information.
  5. Have the designated staff provide the applicant with the entire application package and assist the applicant in completing forms as needed.
  6. Have the designated staff obtain as much documentation as possible of all statements on the application form (DSS-2921) and assist the individual as needed with securing missing documentation.
  7. Follow existing mandates for Immediate Needs and Expedited Food Stamps. For applicants who still are institutionalized, consider Immediate Needs and Expedited Food Stamps based on the applicant's expected situation in the community.
  8. Provide the original application with the completed Applicant Release Agreement, date stamped with the date of receipt by DMH, to DSS using the agreed upon procedures. Information should be hand-delivered to the DSS whenever possible and/or expedited in an agreed upon manner.
  9. Maintain a log, noting the applicant's name, birth date, date of application, and date on which the application was provided to DSS.

10. Keep confidential all information obtained while acting as a Medicaid, Public Assistance, and Food Stamps representative to facilitate the filing of an application for the patient.

The unauthorized release of information collected can result in termination of this agreement for violation of the confidentiality requirements cited below and in Section 136 of the Social Services Law and can result in potential legal action. All persons who are designated to take applications and assist applicants as agreed to by the DSS must sign a confidentiality agreement provided by DSS.

Medicaid Confidential Data (MCD) includes, but is not limited to, names and addresses of Medicaid applicants/recipients, the medical services provided, social and economic conditions or circumstances, the Department of Health's evaluation of personal information, medical data, including diagnosis and past history of disease and disability, any information regarding income eligibility - and amount of Medicaid payment, income information, and/or information regarding the identification of third parties. Each element of Medicaid confidential data is confidential regardless of the document or mode of communication or storage in which it is found.

Note that this Memorandum of Understanding involves Medicaid Data, which is confidential pursuant to the New York Medicaid State Plan requirements, Section 1902(a)(7), 42 U.S.C. Section 1396(a)(7) and federal regulations at 42 C.F.R. Section 431.300 et seq.

Also, pursuant to Section 367b(4) of the New York Social Services Law, information relating to persons applying for and receiving Medicaid shall be considered confidential and shall not be disclosed to persons or agencies without the prior written approval of the New York State Department of Health.

**AIDS/HIV Related Confidentiality Restrictions:**

Also note that MCD may contain HIV related confidential information, as defined in Section 2780(7) of the New York Public Health Law. As required by New York Public Health Law Section 2782(5), the New York Department of Health hereby provides the following notice:

**HIV/AIDS NOTICE**

**This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.**

The DMH agrees that any further disclosure of MCD requires the prior, written approval of the New York State Department of Health (NYSDOH), Medicaid Confidential Data Review Committee (MCDRC). The DMH will require and ensure that the approved agreement, contract or document contains the above Notice and a statement that any other party may not disclose the MCD without the prior, written approval of the NYSDOH MCDRC.

DMH or DSS may withdraw from the program and terminate this Memorandum of Understanding upon 60 days written notice to the other party. Before providing such notice, the party withdrawing from the program must consult with the State Department of Health, the State Office of Temporary and Disability Assistance, and the State Office of Mental Health.

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County Department of Mental Hygiene

County Department of Social Services

\_\_\_\_\_

\_\_\_\_\_

Title

Title

\_\_\_\_\_

\_\_\_\_\_

Date

Date

CONFIDENTIALITY AGREEMENT

I, \_\_\_\_\_, (title) \_\_\_\_\_  
\_\_\_\_\_ at or on behalf of the \_\_\_\_\_  
County Department of Mental Hygiene have been designated to take Medicaid, Public  
Assistance, and Food Stamp applications on behalf of the  
\_\_\_\_\_ County Department of Social Services. I  
understand that all communications, information, and documents received by me in the  
course of accepting the Medicaid, Public Assistance, and Food Stamp application and  
assisting the applicant is confidential and may not be disclosed by me to unauthorized  
personnel or used for any purpose other than determining eligibility for Medicaid, Public  
Assistance, and Food Stamp benefits.

I have read the attached Confidentiality Statement and understand that any violation of  
the provisions of this agreement is unlawful and may subject me to loss of my  
status as a designated interviewer as well as any other penalties prescribed by law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

## Confidentiality Statement

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Note that this Memorandum of Understanding involves Medicaid Data, which is confidential pursuant to the New York Medicaid State Plan requirements, Section 1902(a)(7), 42 U.S.C. Section 396(a)(7) and federal regulations at 42 C.F.R. Section 431.300 et seq.

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The DMH agrees that any further disclosure of MCD requires the prior, written approval of the New York State Department of Health (NYSDOH), Medicaid Confidential Data Review Committee (MCDRC). The DMH will require and ensure that the approved agreement, contract or document contains the above Notice and a statement that any other party may not disclose the MCD without the prior, written approval of the NYSDOH MCDRC.

Applicant Release Agreement

I agree that the information on this application may be shared only with the State Medicaid Program, State Office of Mental Health, the local social services district, local department of mental hygiene and its official designees providing the application assistance, and First Health Services Corporation. I understand this information is being shared for the purpose of determining my eligibility for Medicaid and the Medication Grant Program.

\_\_\_\_\_ Date

\_\_\_\_\_  
Applicant's Signature