NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 20, 2012

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #11-91

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #11-91 to the Title XIX (Medicaid) State Plan effective May 1, 2012 (Appendix I).

A summary of the plan amendment is provided in Appendix II. Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III).

In keeping with our continued agreement, this amendment is being sent to you prior to the end of the second quarter.

If you or your staff have any questions or need any assistance, please contact Karla Knuth, of my staff, at (518) 474-1673.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **#11-91**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **May 1, 2012**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3**	7. FEDERAL BUDGET IMPACT: **a. FFY 05/01/12-09/30/12 $5.25M** **b. FFY 10/01/12-09/30/13 $12.6M**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Section 1: Page 11b, 11c, 11d**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Express Lane Eligibility
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: June 20, 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2011 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Amended SPA Pages

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

1902(e)(13) of the Act

☒ (e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013.

(1) The Express Lane option is applied to:

☐ Initial determinations ☒ Redeterminations
☐ Both

(2) A child is defined as younger than age:
☒ 19 ☐ 20 ☐ 21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

The New York State Department of Health (NYSDOH), Office of Health Insurance Program (OHIP), Division of Coverage and Enrollment (DCE) administers the Medicaid and Child Health Plus (CHPlus, New York's separate CHIP program) programs. At redetermination, New York elects to rely on the finding of ineligibility from the Child Health Plus program to determine the eligibility for the Medicaid program. The State also elects to rely on a finding of ineligibility from the Medicaid agency to determine eligibility for the separate CHIP program at redetermination.

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

(4) The following component/components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

Child Health Plus plans annually renew eligibility for children enrolled in CHPlus. When calculating household income, the first step is to determine if the child is eligible for Medicaid. Currently, when a child renews for CHPlus and screens Medicaid eligible, the child's legally responsible relative must apply for Medicaid on behalf of the child. In order to streamline eligibility for children who screen Medicaid eligible, the Department of Health is implementing a process that will send the eligibility information obtained at the renewal by CHPlus to the Local Departments of Social Services (LDSS). If Medicaid eligible, the child is given two months of temporary CHPlus coverage, and the case information will be sent to LDSS to open a Medicaid case. In upstate counties this process will be done manually and in NYC this will be done electronically.

When a child renews for Medicaid and is determined ineligible due to excess income, an electronic file is sent to CHPlus. CHPlus enrolls the child based on the information obtained from the Medicaid renewal.

Medicaid

The State will use an income finding from CHPlus and apply this income information to enroll a child in Medicaid if a child is found to be ineligible for CHPlus at renewal. Medicaid uses net income to determine eligibility; Child Health Plus uses gross income to determine eligibility.

Medicaid allows a $90/month deduction for each working family member. This deduction does not apply to CHPlus.

Medicaid allows an income deduction for child/dependent care costs. Medicaid provides a deduction of $200/month/child for each child under 2 years and $175/month/child for each child 2 years and older. Medicaid provides a $175 deduction for adult dependent care costs. These deductions do not apply to CHPlus.

In determining eligibility for Medicaid, the State deducts the amount of health insurance premiums paid from the family income. This deduction does not apply to CHPlus.

Medicaid excludes $100 from the total child support received. This disregard does not apply to CHPlus.

Medicaid allows deductions for informal day care provided ($5 per day per child) and appropriate expenses for roomer/boarder income. These deductions are not allowed in CHPlus.

Medicaid and CHPlus both use the same residency rules. Medicaid will accept the CHPlus agencies finding for residency.

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

(5) Check off and describe the option used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI.

☐ (a) Screening threshold established by the Medicaid agency as:

(i) ___ percentage of the Federal poverty level which exceeds the highest Medicaid income threshold

☐ applicable to a child by a minimum of 30 percentage points: specify _____; or

(ii) ___ percentage of the FPL (describe how this reflects the value of any differences between income methodologies of Medicaid and the Express Lane agency: _____

_____); or

☐ (b) Temporary enrollment pending screen and enroll.

☒ (c) State's regular screen and enroll process for CHIP.

☒ (6) Check off if the State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollment.

☐ (7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

Appendix II
2011 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #11-91

This State Plan Amendment proposes to use the Express Lane Eligibility option under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to use a finding of ineligibility in Child Health Plus, New York's Children's Health Insurance Program, at renewal to determine eligibility in the Medicaid program.

Appendix III
2011 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Authorizing Provisions

S. 6608—B/A. 9708—C
CHAPTER 58 OF THE LAWS OF 2010 – PART B

§ 9. Section 2511 of the public health law is amended by adding a new subdivision 2-c to read as follows:

2-c. Express lane eligibility. (a) Notwithstanding any inconsistent provision of law, rule or regulation, the commissioner is authorized to (i) establish standards and procedures for express lane enrollment and renewal implemented in accordance with section 2107(e)(1)(B) of the federal social security act, including but not limited to reliance on a finding made by an express lane agency, as defined in section 1902(e)(13)(F) of the federal social security act, to determine whether a child meets one or more of the eligibility criteria set forth in subdivision two of this section; (ii) specify such standards and procedures in the state child health plan established under title XXI of the federal social security act and applicable contracts with approved organizations and enrollment facilitators; and (iii) waive any information and documentation requirements set forth in this section necessary to implement express lane eligibility pursuant to standards and procedures established under subparagraphs (i) and (ii) of this paragraph; provided, however, that information and documentation required pursuant to subdivision two-b of this section may not be waived.

(b) Subject to federal approval, such standards and procedures shall specify that information and documentation regarding citizenship and immigration status collected by an express lane agency and provided to the commissioner for the purpose of express lane eligibility may be used to satisfy the requirements of subdivision two-b of this section.

(c) Such standards and procedures shall also include a process for determining enrollment error rates and implementing corrective actions as required by section 1902(e)(13)(E) of the federal social security act.

§ 10. Section 366-a of the social services law is amended by adding a new subdivision 11 to read as follows:

11. (a) Notwithstanding any inconsistent provision of law, rule or regulation, the commissioner of health is authorized to (i) establish standards and procedures for express lane enrollment and renewal implemented in accordance with section 1902(e)(13) of the federal social security act, including but not limited to reliance on a finding made by an express lane agency, as defined in section 1902(e)(13)(F) and (H) of the federal social security act, to determine whether a child meets one or more of the eligibility criteria for medical assistance; (ii) specify such standards and procedures in the medical assistance state plan established under title XIX of the federal social security act; and (iii) waive any information and documentation requirements set forth in this section necessary to implement express lane eligibility; provided,

however, information and documentation required pursuant to section one hundred twenty-two of this chapter may not be waived.

(b) Subject to federal approval, such standards and procedures shall specify that information and documentation regarding citizenship and immigration status collected by an express lane agency and provided to the commissioner for the purpose of express lane eligibility may be used to satisfy the requirements of section one hundred twenty-two of this chapter.

(c) Such standards and procedures shall also include a process for determining enrollment error rates and implementing corrective actions as required by section 1902(e)(13)(E) of the federal social security act.

(d) For purposes of a medical assistance eligibility determination made in accordance with this subdivision, a child shall be deemed to satisfy the income eligibility criteria for medical assistance if an express lane agency, as defined in section 1902(e)(13)(F) and (H) of the federal social security act and specified in the standards and procedures established pursuant to paragraph (a) of this subdivision, has determined that: the child's family has income that does not exceed a screening threshold amount, as determined by the commissioner of health, equal to a percentage of the federal poverty line (as defined and annually revised by the United States department of health and human services) that exceeds by thirty percentage points the highest income eligibility level applicable to a family of the same size under the medical assistance program.

Child Health Plus
HEALTH INSURANCE RENEWAL FORM

It is time to renew your child(ren)'s Child Health Plus (CHPlus) coverage!

Please read this entire renewal form before you begin filling out the form. **If you do not complete this form on time, your child(ren)'s health care coverage will end.** Please make sure you answer all the questions on this form or your child(ren) may lose coverage.

If you have questions about what is needed to renew your child(ren)'s coverage or need help completing this form, contact us at:

[Insert Health Plan Contact Information Here]

Do not use this renewal form to add a new child to CHPlus. This form can only be used to renew coverage for children already enrolled in CHPlus who are under the age of 19 and to evaluate existing CHPlus members for Medicaid eligibility. If your child(ren) is found eligible for Medicaid, you may be contacted for more information and will need to complete a new application.

If you would like to add a new child to CHPlus, please contact your health plan or a facilitated enroller to complete a new Access NY Health Care application for that child.

**** Child Health Plus Premium*** - There may be a monthly premium for Child Health Plus. If you are required to pay a premium, one month's payment must be submitted with this form. Please refer to the information on page 6 about family premium contributions to determine the amount of your monthly premium based upon your family's income and household size. If you have any questions or need to know where to mail your premium, please call [Insert Health Plan Name and Phone Number Here].

Important Information About Your Rights - You have the option of changing your CHPlus health plan at anytime, but you will have to obtain and complete a new Access NY Health Care application. You cannot use this renewal form to switch your CHPlus health plan. If your child is disabled or has a chronic illness, he/she may be eligible for Medicaid programs and services. To receive information about changing health plans or to learn about programs for special needs families, call **1-800-698-4543**.

SECTION A: CONTACT INFORMATION

This section should be completed by a parent, guardian, or person renewing coverage on behalf of the child(ren). Tell us who you are and how to contact you.

Legal First Name of Person Completing this Form	**Middle Initial**	**Legal Last Name**	**Sex:** ☐ Male ☐ Female	**What Language Do You** **Speak?** **Read?**
Primary Phone Number What type of number is this? ☐ Home ☐ Cell ☐ Work ☐ Other		**Another Phone Number** What type of number is this? ☐ Home ☐ Cell ☐ Work ☐ Other		**E-Mail Address** Do you want to receive information from your health plan via email? ☐ Yes ☐ No

If known, please provide your child(ren)'s health plan identification number(s): _____ _____ _____ _____

Home Address of the Children Renewing Health Insurance **Did your address change in the past 12 months?** ☐ Yes ☐ No

Street Address			Apartment Number
City	State	Zip Code	County

Mailing Address if Different from the Home Address

Street Address			Apartment Number
City	State	Zip Code	County

SECTION B: ABOUT YOUR HOUSEHOLD

You must answer all of the questions and check all appropriate boxes for each person listed. **DO NOT LEAVE A BOX IN THE ROW BLANK.**

List information about yourself in the first row of boxes. In the other rows, list the name of all the children in the household, spouses, parents, step-parents, and any other children under 21 living with them. You may also list other household members at your option; however, they may not be added to your family size. This information helps us determine the size of your family and which program your child is eligible for.

1. Enter the full legal name of each person living in your household. List yourself in row 01.
2. Indicate how each person listed in this section is related to you (example: spouse, child, step-child, niece, etc).
3. Give the date of birth for each person listed.
4. Write yes or no to indicate if this person is renewing CHPlus coverage. You must write no for all family members who are not renewing CHPlus coverage.
5. Write yes or no if this person is a Public Employee who can get health insurance coverage through a State Health Benefits Plan or the New York State Health Insurance Program (NYSHIP). NYSHIP is offered to employees/retirees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate with NYSHIP. If you are not sure, check with your employer or benefit administrator. If your child has access to a State Health Benefits Plan through NYSHIP, he/she will be ineligible for Child Health Plus coverage.
6. Indicate if this person is male or female.
7. Answer if anyone is pregnant in the household by writing yes or no. You will need to provide proof of pregnancy for anyone that is pregnant (see page 6).
8. Identify whether or not this person is a full time student by writing yes or no.
9. A Social Security Number (SSN) should be provided for any child renewing coverage or household member if they have one. Write Not Applicable (N/A) if this person does not have a Social Security Number.
10. Almost all children are eligible for either CHPlus or Medicaid, regardless of citizenship or immigration status, if they are New York State residents and do not have other health insurance. Please list every child's citizenship and immigration status to help us determine their program eligibility. If your child's immigration status has changed since the last application, you must provide proof of the change for each child (see page 6 for examples of acceptable proof) and give the date the child's immigration status changed. No proof is needed if your child's status has not changed in the last year.

1	2	3	4	5	6	7	8	9	10
Legal Name (First, Middle Initial, Last)	**Relationship to Person in Box 01** (Spouse, Child)	**Date of Birth** (mm/dd/yy)	**Renewing CHPlus Coverage?** (Yes/No)	**Public Employee with State Health Benefits?** (Yes/No)	**Sex** (Male or Female)	**Is this Person Pregnant?** (Yes/No) SEND PROOF	**Full Time Student?** (Yes/No)	**Social Security Number (If you have one)** (XXX-XX-XXXX)	**Citizenship or Immigration Category** (Check a Box) Only enter a date of status if you check the immigrant box (DOS: mm/dd/yy) ONLY SEND PROOF OF A CHANGE
01	Self								☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa Holder) ☐ Immigrant DOS:____/____/____
02									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa Holder) ☐ Immigrant DOS:____/____/____
03									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa Holder) ☐ Immigrant DOS:____/____/____
04									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa Holder) ☐ Immigrant DOS:____/____/____
05									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa Holder) ☐ Immigrant DOS:____/____/____
06									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa Holder) ☐ Immigrant DOS:____/____/____
07									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa Holder) ☐ Immigrant DOS:____/____/____
08									☐ U.S. Citizen ☐ None of these apply ☐ Non-immigrant (Visa Holder) ☐ Immigrant DOS:____/____/____

SECTION C: HOUSEHOLD INCOME

Complete all of the following boxes for all adults living in the household as well as anyone else in the household (including children) who receive income. For each person, indicate what type(s) of income they receive, how much before taxes, and how often (weekly, every 2 weeks, monthly, or annually). If the person is not regularly employed throughout the year, or if the person's income goes up and down every month, write the amount the person expects to receive this calendar year. Do not use an income range or approximations. If there is "No Income" coming into the household, check the box below each person's name and indicate below how the renewing child(ren) are financially supported.

Here is a list of different types of income that you may be receiving and we need to know about:

*** Earnings from Work:** Gross Wages, Salaries, Commissions, Tips, Overtime, and Self-Employment before taxes

*** Unearned Income:** Social Security Benefits (SSB), Disability Payments (SSD), Unemployment Payments, Interest and Dividends, Veteran's Benefits, Workers' Compensation, Child Support/Alimony, Rental Income, and Pension

*** Contributions/Other:** Income (money) from Relatives, Friends, Roomers and Boarders (include money that anyone gives to help meet living expenses), Temporary (Cash) Assistance, Supplemental Security Income (SSI), Student Grants, or Loans

You have two options to give proof of your income.

1. You can provide a Social Security Number for each individual who receives income for us to check (verify). **If you provide a Social Security Number, you do NOT have to provide any income documents with this form.** You must still complete all of the questions in this section.

-OR-

2. You can provide proof of your income for each type of income listed. See page 6 for a list of documents you will need to provide as proof of your income. The proof submitted must be dated within one month prior to the date you sign this form and include the name of the person who gets the income.

Name of ALL Adult(s) in Section B and Other Household Members, Including Children, Who Receive Income	Social Security Number (XXX-XX-XXXX)	Type of Income (Either write your Social Security Number or You Must Send Proof of Your Household Income)		How Much? (Before Taxes)	How Often? (Ex: Monthly)
		Earnings from Work	Name of Employer:	$	
			Name of Employer:	$	
		Unearned Income	List Type :	$	
			Do you receive Child Support? ☐ Yes ☐ No	$	
☐ Check if this person does not receive income.		Contributions/Other	List Type:	$	
		Earnings from Work	Name of Employer:	$	
			Name of Employer:	$	
		Unearned Income	List Type :	$	
			Do you receive Child Support? ☐ Yes ☐ No	$	
☐ Check if this person does not receive income.		Contributions/Other	List Type:	$	
		Earnings from Work	Name of Employer:	$	
			Name of Employer:	$	
		Unearned Income	List Type :	$	
			Do you receive Child Support? ☐ Yes ☐ No	$	
☐ Check if this person does not receive income.		Contributions/Other	List Type:	$	
		Earnings from Work	Name of Employer:	$	
			Name of Employer:	$	
		Unearned Income	List Type :	$	
			Do you receive Child Support? ☐ Yes ☐ No	$	
☐ Check if this person does not receive income.		Contributions/Other	List Type:	$	

NO INCOME: If there is no money coming into the household, explain below how the children renewing coverage are being supported. For example, the children are living with a friend/relative who is paying for their living expenses (room and/or board). If someone is paying your living expenses, you must supply a letter from the person providing support that they have signed and dated. The letter must include their name, address, telephone number and the amount they give you or the children for living expenses as well as how often.

Explanation:

SECTION D: HOUSEHOLD EXPENSES

Dependent Care Complete if anyone listed in Section C pays for the care of a child or a disabled adult in order to go to work or school. Child care/dependent care costs are how much a parent or other adult in the household pays another person to take care of child(ren) or dependent adult(s) while they are working or going to school. Some of this amount may be subtracted from the household's monthly income and will help us determine for which program the child(ren) are eligible. Please note that proof of these costs may be requested if your child appears eligible for the Medicaid program.

Name of Person Being Cared For	Amount Paid	How Often
	$	☐ Weekly ☐ Every 2 Weeks ☐ Monthly
	$	☐ Weekly ☐ Every 2 Weeks ☐ Monthly
	$	☐ Weekly ☐ Every 2 Weeks ☐ Monthly

Health Insurance Complete if anyone listed in Section C pays for health insurance or if in the past 12 months a child renewing CHPlus coverage enrolled in additional health insurance coverage. If the applying children have other health insurance, you must provide proof of the other policy so we can determine if they are eligible (see page 6). Indicate your monthly cost (how much a parent or adult pays per month for their premium) and what type of coverage is provided under this health insurance policy. If you have a health insurance deduction taken from your paycheck stub, please indicate in this section the name of the policy holder and who the policy covers.

Name of Policy Holder	Person(s) Covered	Insurance Company Name	Monthly Cost	Coverage Type SEND PROOF
			$	☐ Comprehensive ☐ Dental Only ☐ Vision Only ☐ Other:
			$	☐ Comprehensive ☐ Dental Only ☐ Vision Only ☐ Other:
			$	☐ Comprehensive ☐ Dental Only ☐ Vision Only ☐ Other:

SECTION E: SIGNATURE

You must sign and date the application. Your application cannot be processed without your signature.

By signing this application, I agree to having the information on this application shared only among Child Health Plus and Medicaid, my health plan, the local social services district, and the facilitated enrollment organization providing application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purposes of determining eligibility of those individuals applying for Child Health Plus or Medicaid or to evaluate the success of these programs. If you do NOT want any information on this application shared for purposes of making an eligibility determination for Medicaid, please check this box: ☐

I agree that any licensed doctor, hospital, or other health care provider may give my health plan information about medical services enrolled members of my family have received, as requested, and to such an extent as may be responsible and necessary for the operation and regulation of the plan. This information will be kept confidential.

I understand that each person renewing/applying for Child Health Plus or Medicaid will be enrolled in the appropriate program, if eligible. I understand that if my child is found eligible for Child Health Plus, he/she will be re-enrolled in the plan listed on page one of this application. I also understand that if my child is found eligible for Medicaid instead of Child Health Plus, he/she will be enrolled in that same managed care health plan unless that health plan does not participate in Medicaid managed care. If my child's plan does not participate in Medicaid managed care, my child will be enrolled in another health plan. If my child lives in a county that does not require enrollees to be in a Medicaid managed care health plan, my child will still be enrolled in a health plan unless I notify my local social services department, in writing, that I do not want him/her to be in a plan.

I have also read and understand the Terms, Rights and Responsibilities included with this form (see page 5). I certify under penalty of perjury that everything on this form is the truth as best I know.

Signature of the Person Listed in Section A: X _____ **Date:** _____

SECTION F: TERMS, RIGHTS and RESPONSIBILITIES

By completing and signing this form, I am renewing Child Health Plus. I understand that this form, notices, and other supporting information will be sent to the program(s) for which I want to renew. I agree to the release of personal and financial information from this form and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information; I agree to immediately report any changes to the information on this form.

I understand that I must provide the information needed to prove eligibility for each program. If I have been unable to get the information for Medicaid, I will tell the social services district. The social services district may be able to help in getting information.

I understand that workers from the programs for which family members or I have applied may check the information given by me for 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.

By applying for CHPlus, I agree to pay the applicable premium contribution not paid by New York State.

I understand that CHPlus and Medicaid will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid, I am giving to the Medicaid agency all of my rights to receive medical support from a spouse or parents of persons under 21 years old and my right to third party payments for the entire time I am on Medicaid. 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, or disability status may be a factor in whether or not I am eligible.

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.

SSNs are not required to enroll in CHPlus. If available, I will include it for children renewing/applying for Medicaid. SSNs are not required for pregnant Medicaid applicants or non-qualified aliens. SSNs are not required for legally responsible adults or any other person residing in the Medicaid applicant's household who is not applying for Medicaid. SSNs are required for Medicaid applicants who are not pregnant. 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. The Medicaid agency and the CHPlus program will use the SSN to verify my income, eligibility and the amount of medical assistance payments made on my behalf. The information may be matched with the records in other agencies, such as the Social Security Administration, Internal Revenue Service or State Department of Taxation and Finance.

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 reimbursement for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purposes of audit.

I consent to the release of any medical information about me and any members of my family for whom I can give consent: (1) by my PCP, any 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; (2) by health plan and any health care providers to SDOH and other authorized federal, state and local agencies for purposes of administration of Medicaid, Child Health Plus and Family Health Plus programs; and (3) 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.

<table>
<tr><td colspan="4">FOR OFFICE USE ONLY</td></tr>
<tr><td colspan="4">To be completed by the person assisting with the application.</td></tr>
<tr><td colspan="2">Signature of Person who
Obtained Eligibility Information:</td><td colspan="2">Employed By: ☐ Health Plan ☐ Social Services District ☐ Provider Agency
☐ Community-Based Facilitated Enrolment Agency. Specify:</td></tr>
<tr><td colspan="4">To be completed by Facilitated Enrollers:</td></tr>
<tr><td colspan="2">Facilitated Enroller Name:</td><td>Lead Agency:</td><td>Lead Org. ID:</td></tr>
<tr><td>Application Start Date (mm/dd/yy):</td><td>Application Sequence Number:</td><td>Application Completion Date (mm/dd/yy):</td><td>Enter Code of Applying Child(ren):
Medicaid _____
CHPlus _____</td></tr>
</table>

Proof of Household Income: If you do not provide your SSN, you must provide ONE proof for each type of income you have. The proof must be dated and received within the last four weeks of the application signature date, whether you get paid weekly, bi-weekly, or monthly.

- **Wages and Salary**
  - Paycheck stubs (4 consecutive weeks)
  - Signed and dated letter from employer on company letterhead with phone #
  - Current signed and dated income tax return and all schedules*
  - Business/payroll records
- **Self-Employment**
  - Current signed and dated income tax return and all schedules*
  - Records of earnings and expenses/business records
- **Unemployment Benefits**
  - Award letter/certificate
  - Monthly benefit statement from the NYS Department of Labor
  - Print out of the recipients account information from the NYS Department of Labor's website - www.labor.state.ny.us
  - A copy of the direct payment card with printout
  - Correspondence from NYS Department of Labor
- **Social Security**
  - Award letter/certificate
  - Annual benefit statement
  - Correspondence from Social Security Administration
- **Child Support/Alimony**
  - Letter from person providing support that is signed, dated, and gives contact information
  - Letter from court
  - Child support/alimony check stub
  - A copy of the New York Eppicard with printout
  - A copy of the child support account information from the following website www.newyorkchildsupport.com
  - Copy of the bank statement showing direct deposit
- **Income from Rent or Room/Board**
  - Letter from roomer, boarder, tenant
  - Check stub
- **Interest/Dividends or Royalties**
  - Recent statement from bank, credit union, or financial institution
  - Letter from broker or agent
  - 1099 or tax return (if no other documentation is available)
- **Support from other Family Members**
  - Statement or letter from family member that is signed, dated, and gives contact information
- **Military Pay**
  - Award letter or Check stub
- **Veteran's Benefits**
  - Award letter or Benefit check stub
  - Correspondence from Veterans Administration
- **Private Pension/Annuities**
  - Statement from pension/annuity
- **Worker's Compensation**
  - Award letter or Check stub

** Income tax returns for other than self employed must be for applications prior to April of the following year.*

Proof of Pregnancy (Provide one of the following): • Presumptive Eligibility Screening Worksheet completed by Qualified Provider that gives your expected date of delivery • Statement from Medical Professional with expected date of delivery • WIC Medical Referral Form that gives your expected date of delivery

Proof of Other Health Insurance (Provide all that apply): • Premium Insurance Policy • Certificate of Insurance • Insurance Card

Proof of Identity, U.S. Citizenship and/or Immigration Status: You are only required to provide proof of your child's citizenship or immigration status if there was a change since last year. The United States Citizenship and Immigration Services (USCIS) has said that enrollment in CHPlus CANNOT affect your child's ability to get a green card, become a citizen, sponsor a family member or travel in and out of the country. The state will not report any of the information on this form to the USCIS.

Provide ONE of the following documents to prove both **Citizenship, Identity,** and your **Date of Birth:**

• U.S. Passport Book/Card **OR** • Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
• Certificate of US Citizenship (DHS Forms N-560 or N-561) **OR** • NYS Enhanced Driver's License (EDL).

If one of the above documents is not available, you must provide **ONE** document from **EACH LIST - Citizenship AND Identity:**

Citizenship • U.S. Birth Certificate* • Certificate of Birth Abroad (Form FS-545)* • Native American Tribal Document*
• Certificate of Report of Birth (Form DS-1350)* • U.S. National ID Card (Form I-197 or I-179)
• Religious/School Records* • Official military record of service showing US Place of Birth
• Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000 • Final adoption decree

Identity • State Driver's license or ID card with photo* • ID card issued by a federal, state, or local government agency
• U.S. Military card or draft record or U.S. Coast Guard Merchant Mariner Card • School ID card with a photo
• Verified School, Nursery or Daycare records (for children under 16) • Clinic, Doctor or Hospital records (for children under 16)* • Certificate of Degree of Indian blood or other Native American/Alaska native tribal document with photo

These lists are not all inclusive. Documents with a * next to it also show Date of Birth.

If you are not a U.S. Citizen: The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status. This list is not all inclusive. If you do not have one of these documents, please call: [Insert Health Plan Phone Number Here].

Immigration Status You can use **ONE** of the following documents to prove both Immigration Status, Identity and Date of Birth:
• I-551 Permanent Resident Card ("Green Card") • I-688B or I-766 Employment Authorization Card

Other documents that may show your Immigration Status, but require an additional Identity document are:
• I-94 Arrival/Departure Record* • USCIS Form I-797 Notice of Action
• Evidence of Continuous U.S. Residence prior to 1/1/1972.

Family Premium Contribution: There may be a monthly premium for Child Health Plus. If you are required to pay a premium, one month's payment must be submitted with this form. There are no premiums for Medicaid. To determine if you need to pay a premium based on your family's monthly income and household size, use the attached table. If you need help understanding your expected CHPlus premium, call 1-800-698-4543 or [Insert Health Plan Phone Number Here]. The full premium varies, depending upon the health plan you choose. Income eligibility levels change at least annually. You may contact your CHPlus plan or visit NY State Department of Health's website at www.nyhealth.gov/nysdoh/chplus for an updated premium and income eligibility table.

Attachment Rev. (01/2012)

Child Health Plus Family Contributions by Income and Household Size

	HOUSEHOLD SIZE						
Premium Categories	**1**	**2**	**3**	**4**	**5**	**6**	**Each Add'l Person**
Free Insurance	$1,451	$1,961	$2,470	$2,979	$3,489	$3,998	$510
$9 / Child / Month (Max $27/Family)	$2,015	$2,722	$3,429	$4,135	$4,842	$5,549	$707
$15 / Child / Month (Max $45/Family)	$2,269	$3,065	$3,861	$4,657	$5,453	$6,248	$796
$30 / Child / Month (Max $90/Family)	$2,723	$3,678	$4,633	$5,588	$6,543	$7,498	$955
$45 / Child / Month (Max $135/Family)	$3,177	$4,291	$5,405	$6,519	$7,633	$8,748	$1,115
$60 / Child / Month (Max $180/Family)	$3,630	$4,904	$6,177	$7,450	$8,724	$9,997	$1,274
Full Premium*/ Child/Month	Over $3,630	Over $4,904	Over $6,177	Over $7,450	Over $8,724	Over $9,997	

*The full premium varies, depending upon the health plan you choose. Income eligibility levels change at least annually. You may contact your CHPlus plan or visit the NY State Department of Health's website at www.nyhealth.gov/nysdoh/chplus for an updated premium and income eligibility table.