NEW YORK STATE DEPARTMENT OF HEALTH
Medicaid Enrollment and Exchange

Information Concerning Medical Assistance For SSI/SSP Beneficiaries

Please Print Clearly

NAME (first, middle initial and last) _____ SOCIAL SECURITY NO. _____ DATE OF BIRTH (month/day/year) _____ ☐ Male ☐ Female SEX

RESIDENCE ADDRESS _____ CITY _____ ZIP CODE _____ TELEPHONE NUMBER _____

MAILING ADDRESS (if different from above) _____ CITY _____ ZIP CODE _____

Medicare Do you have a red, white and blue card from the Social Security Office? ☐ Yes* ☐ No

*If Yes, Claim Number _____

Effective Date: (As appears on your red, white and blue card) _____ HOSPITAL INSURANCE _____ MEDICAL INSURANCE

Do you have health insurance other than Medicaid or Medicare? ☐ Yes ☐ No If yes, complete.

Insurance Company	Effective Date	Policy No.	Group No.	Policy Holder Name	Employer/Union Name	Monthly Cost
1.						
2.						

Do you have medical bills from 3 months before you applied for SSI/SSP up until now? ☐ Yes ☐ No If yes, list below:

Date of Service	Doctor/Hospital/Pharmacy/Other	Amount

NON-DISCRIMATION NOTICE – The information will be considered without regard to race, marital status, sex, handicaps, religion, ethnic background, national origin, political beliefs or age.

CHANGES – I agree to inform the agency promptly of any change in the above to the best of my knowledge or belief.

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

DIRECT PAYMENT – I authorize the payment of my health or accident insurance benefits to be made directly to the appropriate Social Services official for medical and other health services furnished while I am eligible for Medical Assistance.

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

INFORMATION REGARDING LIENS AND RECOVERIES – If you receive Medical Assistance, a lien may be filed and a recovery may be made against your real property under certain circumstances if you are in a medical institution and not expected to return home. However, no lien will be filed against your home if one of the following persons is living there: your spouse; your child who is under age 21 or who is certified blind or disabled; your brother or sister, if he or she has a right to part of your home and lived there for a least one year immediately before you went into the medical institution. In addition, any lien placed against your real property will be removed if you return home from the institution.

A recovery may be made from your estate for Medical Assistance you received when you were 55 years of age or older. However, no such recovery will be made at a time when you are survived by your spouse or by a child who is under age 21 or who is certified blind or disabled.

Medical Assistance paid on your behalf may be recovered from persons who had legal responsibility for your support at the time medical services were obtained.

X _____ _____
SSI/SSP BENEFICIARY/REPRESENTATIVE SIGNATURE DATE SIGNED

X _____ _____
HUSBAND/WIFE PROTECTIVE REPRESENTATIVE DATE SIGNED

PLEASE READ THIS FORM CAREFULLY AND BE SURE TO SIGN YOUR NAME.
RETURN THIS FORM AND THE ENCLOSED LETTER TO YOUR LOCAL SOCIAL SERVICES DISTRICT OFFICE.