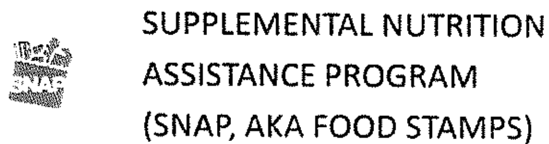
CORE BENEFITS AND PROGRAMS:

CASH ASSISTANCE

EMPLOYMENT SERVICES


SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP, AKA FOOD STAMPS)

MEDICAL INSURANCE

CHILD SUPPORT ENFORCEMENT

HOMELESSNESS PREVENTION AND SERVICES

ASSISTANCE FOR THE MOST VULNERABLE NEW YORKERS:

IMMIGRANT SERVICES AND LANGUAGE ACCESS

IDNYC

HIV/AIDS SERVICES ADMINISTRATION

HOME CARE SERVICES

ADULT PROTECTIVE SERVICES

DOMESTIC VIOLENCE SERVICES

EMERGENCY FOOD SERVICES

HOME ENERGY ASSISTANCE PROGRAM

for professionals only 929-221-0865

Eligibility Information Services

2016 Community Training Schedule

TOPIC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Medicaid Prescreening Training for Disabled, Aged, and Blind Eligibility (9 AM - 5 PM)	20 & 21	10 & 11	9 & 10	19 & 20	18 & 19	8 & 9	13 &14	10 &11	14 & 15	26 & 27		7 & 8
Medicaid Advance Training for Disabled, Aged, and Blind Eligibility (9 AM - 5 PM) *only for staff that has attended the DAB training*			16					17				
Nursing Home Training - On Site 505 Clermont Avenue for Nursing Home staff only (9 AM - 5 PM)						15/21/ 23/28/ 30						
Medicaid Training for New Hospital Staff at Greater NY Hospital				4 & 5						19 & 20		
Medicaid Excess Income Training (1 PM - 5 PM) *only for staff that has attended the DAB training*		24							27			
Medicare Saving Program (MSP) (1 PM - 5 PM)				14						5		

To register for the training classes call, Amanda Sierra at 929-221-0869

Hospital Eligibility training at Greater New York Hospital Association are mailed from GNY. Eligibility Information Services does **not** register staff for this trainings.

Medical Insurance and Community Services Administration (MICSA) Eligibility Information Services – 505 Clermont Avenue, Brooklyn, NY 11238

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

March 4, 2016

Medicaid Recipients (with Waiver Services) Active on New York State Marketplace Who Need to be Transitioned to HRA/Medicaid

The following is to inform Client Representatives, Agencies providing Waiver Services and Medicaid providers that the process for transitioning New York State of Health Exchange consumers in need of Waiver services to HRA, has been streamlined.

These consumers no longer have to complete an Access New York Medicaid Application (DOH-4220) and Supplement A (DOH-4995). Requests for transition, as described below, can now be submitted to:

hxfacility@health.ny.gov
(518) 473-6397 voice
(518) 474-9062 fax

When submitting via Email, you must password protect file.

Request for transition need to include the following consumer demographic information:

- NAME
- DOB
- CIN
- HX Account Number
- Type of waiver service in which the consumer has been enrolled or is pending enrollment

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
Medical Assistance Program• Office of Eligibility Information Services • 785 Atlantic Avenue, Brooklyn, NY 11238
Steven Banks, *Commissioner* • **Karen Lane,** *Executive Deputy Commissioner* •**Maria Ortiz-Quezada**, *Director of EIS*

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Note: The request must include proof., such as a Notice of decision (NOD) of the consumer's waiver status (pending or enrolled)

Once approved, the New York State of Health will send cases to HRA with five (5) months of coverage (current month plus four months prospective) established in the Welfare Management System(WMS). This will place the consumer in an upcoming renewal/recertification cycle.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

MEDICAL REQUEST FOR HOME CARE

HCSP- M11Q 12/09/2014

Return Completed Form to:

GSS District Office ______________ Attn: Case Load No. ______________

Address ______________ Borough ______________

Zip Code ______________ Tel. No. ______________

Date Returned to/Received byGSS

FOR GSS USE ONLY

1. CLIENT INFORMATION

Patient's Name	Birthdate	Social Security Number		Medicaid No.
Home address (No. & Street)		Borough	Zip Code	Telephone No.
Hospital/Clinic Chart No.		Contact Person		Contact Tel. No.

II. MEDICAL STATUS

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA/ Dept. of Social Services in connection with my request for home care.

Date: ______________ Signature(X) ______________

How long have you treated the patient? ______ Date of this Examination: ______ Place of this Examination: ______ Date of next Examination: ______

A. CURRENT CONDITION

Check(✓) prognosis of each

Date of Onset		Anticipated Recovery 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
	1. Primary Diagnosis/ ICD Code			
	2. Secondary Diagnosis/ ICD Code			
	3.			
	4.			
	5.			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN: (Hospital Name) ______________

Admission Date: ______________

Reason for Hospitalization: ______________

Expected Date of Discharge:

C. MEDICATION	Dosage	Oral or Parenteral	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Indicate patient's ability to take medication: (*)

1. ☐ Can self-administer
2. ☐ Needs reminding
3. ☐ Needs supervision
4. ☐ Needs help with preparation
5. ☐ Needs administration

(*) If patient CANNOT self-administer medication

(a) Can he/she be trained to self-administer medication? ☐ Yes ☐ No If no, indicate why not: ______________

(b) What arrangements have been made for the administration of medications? ______________

D. MEDICAL TREATMENT

Does the patient receive any of the following medical treatment? ☐ Yes ☐ No
Indicate medical treatment currently received: (✓)

1. Decubitus Care	
2. Dressings: Sterile	
Simple	
3. Bed bound Care (turning, exercising, positioning)	
4. Ambulation Exercise	
5. ROM/Therapeutic Exercise	
6. Enema	

7. Colostomy Care	
8. Ostomy Care	
9. Oxygen Administration	
10. Catheter Care	
11. Tube Irrigation	
12. Monitor Vital Signs	
13. Tube Feedings	
14. Inhalation Therapy	

15. Suctioning	
16. Speech/Hearing/ Therapy	
17. Occupational Therapy	
18. Rehabilitation Therapy	
19. Indicate any special dietary needs	
20. Other	

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

____

____

____

Based on the medical condition, do you recommend the provision of service to assist with personal care and/or light housekeeping tasks?

☐ Yes ☐ No

Please indicate contributing factors (e.g. limited range of motion, muscular motor impairments, etc.) and any other information that may be pertinent to the patient's need for assistance with personal care services tasks.

____

____

____

____

Can patient direct a home care worker? ☐ Yes ☐ No If no, explain below:

____

____

E. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered
Cane			
Crutches			
Walker			
Wheelchair			
Hospital Bed			
Side Rails			

	Has	Needs	Ordered
Bedpan/Urinal			
Commode			
Diapers			
Hoyer Lift			
Dressings			
Respiratory Aids			

	Has	Needs	Ordered
Bath Bar			
Bath Seat			
Grab Bar			
Shower Handle			
Other (Specify)			

If any needed equipment was not ordered, what other plans have been made to meet this need?

____

____

____

SSN: _______________

F. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, Hospice, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? Yes ☐ No ☐

*IDENTITY AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

G. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care. If necessary, please attach an additional sheet(s) explaining the patient's condition in greater detail.

Signature of Person Completing Additional Comments Section	Title	Date
	Agency	

Physician's Certification

I, the undersigned physician, certify that this patient can be cared for at home, and that I have accurately described his or her medical condition, needs and regimens, including any medication regimens, at the time I examined him or her. I understand that I am not to recommend the number of hours of personal care services this patient may require. I also understand that this physician's order is subject to the New York State Department of Health regulations at part 515, 516, 517, and 518 of title 18 NYCRR, which permit the department to impose monetary penalties on, or sanction and recover overpayments from, providers or prescribers of medical care, services or supplies when medical care, services or supplies that are unnecessary, improper or exceed the patient's documented medical condition are provided or ordered.

*(PRINT) Physician's Name | Specialty | *Physician's Signature | Intern ____ Resident ____

*Business Address | *City | *State | *Zip Code

Signature date must be within thirty days after medical exam of patient.

*Date Form Completed | *Registry Number | *NPI Number | *Physician's Telephone | Physician's E-mail

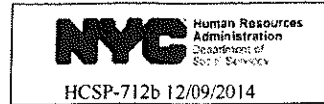
Indicate where form was completed:

Hospital/Clinic/Institution Name | Address | Telephone No. / E-mail

If Nurse /Social Worker/other person assisted in completing this form:

Name | Title | Address | Telephone No. / E-mail

*Mandatory



* Please provide this sheet to the physician filling out the Medical Request for Home Care (M-11Q).

Eight Helpful Hints for Accurate Completion of the Medical Request for Home Care (M-11Q)

1. The client's name, address and Social Security number must be provided.
2. The medical professional must complete the M-11Q by accurately describing the patient's medical condition.
3. The medical professional must not recommend or request the number of hours of personal care services.
4. The M-11Q must be signed by a NY State licensed physician.
5. The date of the examination must be provided.
6. The physician must sign and date the M-11Q within 30 days after the exam date.
7. The registry number, NPI (national provider ID), and the complete business address of the physician must be indicated.
8. The completed signed copy of the M-11Q must be forwarded within 30 calendar days after the medical examination.

EIGHT HELPFUL HINTS FOR ACCURATE COMPLETION OF THE MEDICAL REQUEST FOR HOME CARE (M11Q)

NYC Human Resources Administration
Department of Social Services

HCSP-712b (E) 11/05/2015

1. The client's name, address and Social Security number must be provided.
2. The medical professional must complete the M-11Q by accurately describing the patient's medical condition.
3. The medical professional should **not** recommend or request the number of hours of personal care services.
4. The M-11Q must be signed by a NY State licensed physician.
5. The date of the medical examination must be provided.
6. The physician must sign and date the M-11Q **within** 30 days after the medical examination date.
7. The registry number, National Provider ID (NPI) and the complete business address of the physician must be supplied.
8. The completed and signed copy of the M-11Q must be forwarded to us **within** 30 calendar days after the medical examination.

Note: Please give this sheet, or a copy, to the physician filing out the Medical Request for Home Care (M-11Q).

NYC Human Resources Administration
Department of Social Services

HELP FOR PEOPLE WITH DISABILITIES

Do you have a disability, medical condition or mental health condition that makes it hard for you to apply for or get benefits from us?

For example:

- Does your condition make it hard for you to use public transportation?
- Do you need help to get to appointments?
- Does your condition make it hard for you to wait for long periods of time?
- Is it hard for you to read, understand or fill out forms?
- Do you need help because of a vision or hearing impairment?
- Do you need other help because of your condition?

If you do, we may be able to help you. This help is called a reasonable accommodation.

HOW TO ASK FOR A REASONABLE ACCOMMODATION

ASK: You can ask for help when you come to an HRA office or center

CALL: 212-331-4640

You can also write us or fill out the request on the other side of this form and give it to us by:

FAX: 212-331-4685

EMAIL: ConstituentAffairs@hra.nyc.gov

MAIL: HRA
Office of Constituent Services
150 Greenwich street, 35th Floor
New York, NY 10007

GET HELP WITH THIS FORM!

You can get help with this form or with your request.

CALL: 212-331-4640 or **VISIT:** your center or HRA office

Turn this page over to complete the Reasonable Accommodation Request Form. ➡

HELP FOR PEOPLE WITH DISABILITIES
REASONABLE ACCOMMODATION REQUEST FORM

Do you have a disability, medical condition or mental health condition that makes it hard for you to apply for or get benefits from us? **If you do,** please fill out this form. **If you do not,** you don't need to fill out this form.

YOUR INFORMATION

Name: ______________________ Date: ______________

Case Number: ______________________ Date of Birth: ______________

Phone Number 1: ______________ Phone Number 2 *(if any)*: ______________

Address: ______________________________________

____

WHY DO YOU NEED HELP?

Tell us how your condition makes it hard to access HRA benefits and services *(If you need more space to write, please attach pages)*:

____

____

____

____

Choose WHAT help you might need because of your condition:

- ☐ Help for people who are blind or visually impaired
- ☐ Making appointments when you can have someone come with you
- ☐ No appointments during certain days and times
- ☐ No appointments during rush hour
- ☐ Shorter wait times
- ☐ Transfer your case to center __________
- ☐ Help for people who are deaf or hearing impaired
- ☐ Sign language interpretation
- ☐ No in-office appointments while you apply for Access-A-Ride
- ☐ Help reading forms
- ☐ Help completing forms
- ☐ You need HRA to come to your home for appointments
- ☐ Keep your case at your center __________
- ☐ Other accommodations that you need to access services at HRA. *Explain:*

____

____

____

How long do you think that you will need this help? ______________________

You do not need to give us proof of your condition now. We may ask you to give us some medical or clinical documents later.

To be completed by HRA worker if submitted at an HRA location *(Please give a copy to the client)*:

Date Received: ______________________ Location: ______________________

______________________ ______________________

Name of HRA worker (Print) Signature