Request for Financial Assistance – Terms, Rights, and Responsibilities

- By placing my initials in the consent box, I am signing this application under penalty of perjury. This means that I have provided true answers to all of the questions to the best of my knowledge. I may be subject to penalties under federal law if I have intentionally provided false or untrue information.
- I know that I must tell the Marketplace if anything changes from what I wrote on this application. I should call 1-855-355-5777 or visit www.nystateofhealth.ny.gov to report any change or for help getting required information.
- I know that it is against federal law to discriminate on the basis of race, color, national origin, sex or disability. I can file a discrimination complaint by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is living in a medical facility.

If anyone on this application qualifies for the Essential Plan:

- I understand that if NY State of Health determines me or anyone on this application eligible for the Essential Plan, we are not eligible for Medicaid or the premium tax credit. This means that NY State of Health cannot allow us to enroll into a qualified health plan (with or without a premium tax credit) or a Medicaid Managed Care Plan.
- I know that if I qualify for the Essential Plan, I must choose and join an Essential Plan health plan.
- By applying for the Essential Plan, I agree to pay any monthly fee (premium) not paid by New York State.

If anyone on this application qualifies for Advanced Premium Tax Credits:

- I know that if I am employed, NY State of Health may notify my employer that I have applied for and that the Marketplace determined me eligible for the premium tax credit. Federal law requires that NY State of Health send this notice based on an eligibility determination. NY State of Health may send this notice even if I do not enroll in a health plan. If NY State of Health sends the notice, it may give my employer enough information to identify me.
- I know that if I am employed, the Marketplace may contact any of the employers on this application to see if anyone on this application qualifies for health insurance. The Marketplace will let me know if they get any information that affects whether I qualify for insurance.

Right to appeal

If I think the Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Marketplace that I think the decision is wrong and to ask for a fair review of the decision. I know that I can find out how to appeal by calling 1-855-355-5777. I know that I can have someone other than myself represent me in my appeal. Information about whether I qualify, as well as other important information, will be explained to me. I understand that a change in my information could affect whether people in my household qualify for health insurance.

Additional Terms, Rights, and Responsibilities

When I sign this application, it means I understand that I am applying for Medicaid. I also agree to the release of personal information, financial information, and any other information the state needs in order to decide if I qualify for the program.

My Rights

- I know the Marketplace may use my age, disability, and citizenship or immigration status to determine if I qualify, depending on the rules of the program.
- If understand that I have a right to ask, now or later, to get back money I paid for covered medical care, services, and supplies during the last three months. After the date of my application, any money I spend on covered medical care, services, and supplies will only be paid back if I use Medicaid providers.
- I have the right to say that I have a "good cause" (a good reason) not to sign up for health insurance if I think that signing up for it could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I know that if I need help with my application I can call 1-855-355-5777. The call is free. TTY: 1-800-6621220.

Health Care Proxy

The New York Health Care Proxy Law allows you to choose someone you trust to make health care decisions for you if you can't make them for yourself. This person is called a health care agent.

You can learn more about the New York State Health Care Proxy Law and get the form for a health care agent (proxy form) on the New York State Department of Health website at www.health.state.ny.us/professionals/patients/health_care_proxy/

To get a copy of the form mailed to you, call the New York State Medicaid Help Line at 1-800-541-2831.

My responsibilities

- I must provide all the information needed to prove that I qualify for Medicaid. I understand that the state may ask me for more information.

When I sign this application, it means:

- I know that Medicaid will not pay medical expenses that insurance or another person is supposed to pay.
- I give the Department of Health any right under the law to try to get payment for medical expenses from my spouse.
- I give the Department of Health the right to get paid, instead of me, the money owed to me by certain other companies or people in order to pay for my benefits.
- I agree to file any claims for health or accident insurance benefits, or any other claims for money or benefits, that I have a right to file.
- I understand that effective April 1, 2014, if I get Medicaid through NY State of Health: ○ No lien will be placed on my real property prior to my death.

- Recovery from assets in my estate upon my death is limited to the amount Medicaid paid for the cost of nursing home care, home and community-based services, and related hospital and prescription drug services received on or after my 55th birthday.

- I understand that Medicaid may also get back the cost of services and bills from providers that should not have been paid.
- I understand that anyone who is applying for benefits must give a Social Security Number (SSN) except if they are a non-qualified alien.
- I understand that SSNs may also be used by Medicaid agencies to identify the person getting benefits, so that Medicaid can be sure that the right person is getting the right services.
- This is the law: 42 U.S.C. 1320b-7(a) Medicaid regulation 42 CFR 435.910.

Medicaid Managed Care

- I know that if I qualify for Medicaid, I must choose and join a Medicaid Managed Care Health Plan.
- I can call 1-855-355-5777 to choose a plan.
- I understand that in Medicaid Managed Care, I must choose a doctor to be my Primary Care Provider (PCP). I will be able to choose from at least three PCPs in my health plan.
- I understand that once I join a health plan, I will have to use my PCP and other providers in the plan, except in a few special circumstances.
- I understand that if I have a child while I am a member of a Medicaid Managed Care Health Plan, my child will be enrolled in the same health plan that I am in.

Release of medical information

- I agree to the release of any medical information about me and any members of my family by my: ○ PCP or any other health care providers or the New York State Department of Health, to my health plan and any health care providers caring for me or my family. This is so that my health plan or my providers can carry out treatments, payment, or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
    - Health plan, and any health providers, to the New York State Department of Health and other authorized federal, state, and local agencies so that they can administer Medicaid, and Child Health Plus programs; and ○ Health plan to other persons or organizations so that my health plan can carry out treatment, payment, or health care operations.
- I understand that the information my health plan releases may be about HIV, mental health, alcohol and substance abuse, or a disability. It may also be information needed to see if someone applying qualifies for disability services.
- I understand that if more than one adult in the family is joining a Medicaid health plan, each adult must sign this application to give the plan permission to release information.
- I know that anytime I want to, I can take away the permission I gave to release information. All I have to do is to call my health plan.

Information for Immigrants

I certify, under penalty of perjury, that I or someone for whom I am signing is a U.S. citizen or a National of the United States or has satisfactory immigration status. The term "satisfactory immigration status" means an immigration status that makes the person eligible for benefits.

The federal immigration agency says that enrolling in Medicaid cannot affect a person's ability to get a permanent resident card (green card) or to become a citizen, sponsor a family member, or to travel in and out of the country, unless Medicaid is being used to pay for long-term care services in a nursing home or mental health facility.

The state will not report any information on this application to a federal immigration agency.