

ASSISTANCE WITH YOUR MEDICAID RENEWAL / FREE INTERPRETATION SERVICES

This booklet will help you complete your Renewal. We have included an English and a translated version. Return **only** one. For help with your Renewal, call the HRA Medicaid Helpline at 1-888-692-6116 or contact one of the Managed Care Plans listed on Page 4 of this booklet. Hearing impaired consumers may call 711 or 1-718-636-7783 with a Text Telephone (TTY) device (not a standard phone).

Free interpretation services are available over the phone or in any Medicaid office.

MEDICAID 续期协助 / 免费口译服务

本手册帮助您完成续期。我们提供英文版和翻译版本的手册，但您只需返回其中一个版本。如需协助完成续期，请拨打 HRA Medicaid 帮助热线 1-888-692-6116，或者联系本手册第 4 页所列的其中一个管理式护理计划 (Managed Care Plans)。听障客户可使用短信电话 (TTY) 设备（非标准电话）拨打 711 或 1-718-636-7783。

我们可通过电话或在任何 Medicaid 办事处现场提供免费口译服务。

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MAIL RENEWAL CHANGES

You may continue to call the HRA Medicaid Helpline at 1-888-692-6116 if you have any questions about your Renewal Form. You can also contact one of the Managed Care Plans listed on Page 4 of the enclosed Guide to Complete your Medicaid Renewal Forms for assistance.

This is the **only Renewal** Application that will be automatically sent to you. Please keep it in a safe place until you are ready to return it to us. **We must receive your reply through the mail by the date printed on Page 1 of the Application, or your coverage may end.**

You can still pre-screen for additional benefits at the Access NYC site. It can be accessed by going to <http://www1.nyc.gov> and selecting Social Services from the menu located at the bottom of the page. The site is safe, secure and easy to use.

Note:

- You do not need to send proof of US citizenship at this time. You also do not need to send proof of income unless the Renewal Form instructs you to do so.
 - If you would like, you may send either or both now to help ensure that we have your most accurate information.
 - If you decide not to send proof now, we may write you to request that you do so at a later date. The “Documentation Guide” on Pages 5 and 6 of this booklet show you the types of proofs that we accept.
- If you tell us that you are a US citizen, we will attempt to verify citizenship using a computer match. If we are unable to do so, we will write to you to let you know that and request that you send us proof.
- We will also attempt to verify your income using a computer match. If the match results are different than your self-reported information, the match results may be used when determining your eligibility.
 - If you decide not to send proof now, we may write you to request that you do so at a later date. The “Documentation Guide” on Pages 5 and 6 of this booklet show you the types of proofs that we accept.
- If you recently moved from New York City to another county within New York State, but have not yet had a public health insurance case opened where you now live, you should complete and return this Renewal Form to us. We will assist you in transferring your coverage.

邮件续期变更

如果对您的续期表有任何疑问，同样可拨打 HRA Medicaid 帮助热线 1-888-692-6116。您也可联系所附 Medicaid 续期表填写指南第 4 页中所列的其中一个管理式护理计划寻求协助。

这是自动发送给您的**唯一一份续期申请表**。在填好寄回给我们之前，请妥善保管。**我们必须在申请表第 1 页上印刷的日期截止收到您寄回的邮件，否则您的保险可能会终止。**

您也可在 Access NYC 网站上预先筛选，获取其他福利。访问 <http://www1.nyc.gov>，从页面底部的菜单中选择 Social Services（社会服务）即可评估。该网站安全、简单易用。

注：

- 现在您无需递交美国公民证明文件。除非续期表单有相关说明，否则您也无需递交收入证明。
 - 如果您愿意，现在也可以递交美国公民证明文件和/或收入证明，以帮助我们获得您最准确的信息。
 - 如果您决定暂时不递交证明，我们以后可能会写信要求您发送。本手册第 5 页和第 6 页的“文件指南”列出了我们接受的证明文件类型。
- 如果您告诉我们您是美国公民，我们会尝试通过计算机匹配来核实公民身份。如果无法确认，我们会写信给您告知此事，并要求您发送证明。
- 我们还会尝试通过计算机匹配来核实您的收入。如果匹配的结果与您上报的信息不符，那么在确定您的资格时将会采用匹配结果。
 - 如果您决定暂时不递交证明，我们以后可能会写信要求您发送。本手册第 5 页和第 6 页的“文件指南”列出了我们接受的证明文件类型。
- 如果您最近从纽约市搬至纽约州的另一个县，但在您现在居住的地方还没有公共健康保险案件进行审理，您应填写本《续期表单》并返还给我们。我们将协助您进行保险转移。

参与 MEDICAID 的管理式护理计划

| <p>MEDICAID PARTICIPATING MANAGED CARE PLANS PLANES DE ATENCIÓN ADMINISTRADA PARTICIPANTES DE MEDICAID 參與 MEDICAID 的管理式醫療計畫 (MANAGED CARE PLAN) PLAN SWEN KONTWOLE MEDICAID K AP PATISIPE УЧАСТВУЮЩИЕ В ПРОГРАММЕ MEDICAID ПЛАНЫ КООРДИНИРОВАННОГО ОБСЛУЖИВАНИЯ MANAGED CARE MEDICAID 참여 의료 관리 플랜 (Participating Managed Care Plan) MEDICAID خطط الرعاية المدقرا المشاركة التابعة لـ MEDICAID এ অংশগ্রহণকারী পরিচালিত পরিচর্যার পরিকল্পনাসমূহ RÉGIMES DE SOINS GÉRÉS PARTICIPANT À MEDICAID PLANY UCZESTNICZĄCE W OPIECE ZARZĄDZANEJ MEDICAID MEDICAID میں شرکت کرنے والے منضبط نگہداشت کے منصوبے 参与 MEDICAID 的管理式护理计划</p> | <p>TELEPHONE NUMBER NUMERO TELEFONO 電話號碼 NIMEWO TELEFÒN НОМЕР ТЕЛЕФОНА 전화번호 رقم الهاتف টেলিফোন নম্বর NUMÉRO DE TÉLÉPHONE NR TELEFONU تیلیفون نمبر 电话号码</p> | <p>CURRENT SERVICE AREA Area Actual de Servicio 目前服務地區 Zòn Sèvis Aktyèl Район обслуживания 현재 서비스 지역 منطقة الخدمة الحالية বর্তমান পরিষেবা ক্ষেত্র ZONE DE SERVICE ACTUELLE OBEČNY REGION USŁUG خدمت کا موجودہ علاقہ 当前服务地区</p> | | | | |
|---|--|--|-------|------|-----|-------|
| | | 布朗克斯区 | 布鲁克林区 | 曼哈顿区 | 皇后区 | 史坦顿岛区 |
| AFFINITY HEALTH PLAN | 866-247-5678 | ● | ● | ● | ● | ● |
| EMBLEM HEALTH (formerly GROUP HEALTH INSURANCE/HIP HEALTH PLAN OF GREATER NY- GHI/HIP) | 800-447-8255 | ● | ● | ● | ● | ● |
| HEALTHFIRST PHSP, INC. | 866-463-6743 | ● | ● | ● | ● | ● |
| HEALTHPLUS AN AMERIGROUP COMPANY | 800-950-7679 | ● | ● | ● | ● | ● |
| METRO-PLUS (METROPOLITAN HEALTH PLUS) | 800-303-9626 | ● | ● | ● | ● | ● |
| NY STATE CATHOLIC HEALTHPLAN/FIDELIS | 888-343-3547 | ● | ● | ● | ● | ● |
| UNITED HEALTHCARE COMMUNITY PLAN (formerly AMERICHOICE BY UNITED/ AMERCHOICE OF NY INC.) | 800-493-4647 | ● | ● | ● | ● | ● |
| WELLCARE OF NY, INC. | 800-308-2571 800-215-1531 | ● | ● | ● | ● | ● |
| MEDICAID RENEWAL SITE | 785 Atlantic Ave. Brooklyn, NY 11238 | 888-692-6116 | | | | |

DOCUMENTATION GUIDE TO CONTINUE YOUR HEALTH CARE COVERAGE

Here is a list of proofs the Medical Assistance Programs accepts. Please use this guide with the Instructions on the cover of the Renewal Notification Booklet to determine what documents you may need to provide in order to continue health care coverage.

INCOME:

Wages and Salary/Employment

- Current paycheck/stub(s) or payroll records
- Detailed written statement from employer
- W-2 (MBI-WPD consumers only)
- Income tax return (MBI-WPD consumers only)

Self Employment

- Signed income tax return
- Records of earnings and expenses

Work Income

- If salary stays the same -----> Copy of last pay stub or letter from employer.
- If salary changes from pay period to pay period -----> Copies pay stubs covering last 4 weeks or letter from employer.
- If any part of your salary/income is paid in cash and your employer will not provide written proof -----> Answer "Yes" to the first question at the bottom of the **INCOME** section of Page 2 of Renewal Booklet
- If self-employed -----> Copy of most recent tax return and letter (signed by you) of current income. If income has changed, explain why.
- If receiving unemployment benefits -----> Send copy of unemployment insurance award letter or internet Printout from the NYS Department of Labor: <https://ui.labor.state.ny.us/UBC/home.do>

Type of Proof

Unemployment Benefits

- Award Letter/certificate
- Benefit statement or print-out
- Letter from NYS Department of Labor

Social Security

- Award Letter/certificate
- Benefit check
- Letter from Social Security Administration

Private Pensions/Annuities

- Statement from pension/annuity

Child Support/Alimony

- Letter from person providing support or letter from court
- Child support/alimony check stub

Worker's Compensation

- Award Letter
- Check stub

Income from Rent or Room/Board

- Letter from roomer, boarder, tenant
- Check stub

Military Pay

- Award Letter
- Check stub

Veteran's Benefits

- Award Letter
- Benefit check stub
- Letter from Veterans' Administration

Interest/Dividends/Royalties

- Letter from bank or credit union
- Letter from broker
- Letter from agent

CITIZENSHIP (If you are declaring to be a US citizen, you do not need to send proof at this time. If documents are needed, you will receive a letter requesting them.)

- US Passport
- Certificate of U.S. Citizenship
- Certificate of Naturalization
- U. S. Birth Certificate **and one** of the following **identity** proofs: (1) Driver's license with photograph, or other identifying information (2) School identification card with photograph, (3) U.S. military card or draft record, (4) ID card issued by Federal, State or local government with the same information included on a driver's license.

IMMIGRATION STATUS: The following are documents issued by United States Citizenship & Immigration Services (USCIS)

- I-551 Permanent Resident Card (Green Card)
- I-688B or I-766 Employment Authorization Card
- I-94 Arrival/Departure Record
- I-797 (Notice Of Action) or other official correspondence to and from USCIS, ICE or EIOR

CHILDCARE/DEPENDENT CARE: Documents must include the amount you pay and how often

- Letter from day care center or other child/adult care provider
- Canceled checks or receipts that prove payment of care services

PREGNANCY:

- Statement from doctor/medical professional with expected date of delivery

PRIVATE HEALTH INSURANCE: Documents must include the amount you pay

- Insurance policy
- Certificate of insurance
- Insurance card
- Other proof of private insurance

WE ACCEPT PHOTOCOPIES OF ALL DOCUMENTS OTHER THAN THOSE REQUIRED TO PROVE YOUR CITIZENSHIP OR IDENTITY

医疗保险续期文件指南

下面列出了医疗援助计划接受的证明文件清单。请使用本指南，结合续期通知手册封面的说明确定您需要提供哪些文件，以继续享受医疗保险。

收入：

工资和薪水/就业

- 当前工资单/工资条或工资记录
- 雇主详细的书面声明
- W-2 (仅 MBI-WPD 客户)
- 所得税申报表 (仅 MBI-WPD 客户)

自我雇佣

- 已签署的所得税申报表
- 收支记录

工作收入

- 如果工资没有变化 -----> 最近一次工资单复印件或雇主的证明信。
- 如果每次发薪期的工资有所变化 -----> 最近 4 周的工资单复印件或雇主的证明信。
- 如有任何工资/收入部分是以现金发放，并且您的雇主不提供书面证明 -----> 对续期手册第 2 页收入部分底部的第一个问题回答“是”
- 如果是自我雇佣 -----> 最近纳税申报单的复印件和当前收入证明信 (有您的签名)。如果收入有变化，请说明原因。
- 如果享有失业福利 -----> 递交纽约劳工署 (NYS Department of Labor) 发放的失业保险发放函或网上打印单：<https://ui.labor.state.ny.us/UBC/home.do>

证明类型

失业福利金

- 发放函/证明
- 福利报表或打印单
- 纽约劳工署信件

社会安全金

- 发放函/证明
- 福利支票
- 社会安全局提供的信函

私人养老金/年金

- 养老金/年金报表

子女抚养费/赡养费

- 抚养人信函或法庭信函子女抚养费/赡养费支票存根

工伤赔偿金

- 发放函
- 支票存根

从租金或客房/寄宿获得的收入

- 房客、寄宿者、承租人信函
- 支票存根

军人薪金

- 发放函
- 支票存根

退伍军人福利

- 发放函
- 福利支票存根
- 退伍军人管理局 (Veterans Administration) 的信函

利息/股息/版税

- 银行或信用合作社的信函
- 经纪人信函
- 代理人信函

公民身份 (如果您宣称是美国公民，则暂时无需递交证明。如果我们需要您提供文件，您会收到一封要求您提供文件的信函。)

- 美国护照
- 美国公民证书
- 入籍证书
- 美国出生证和以下一种身份证明：(1) 带照片的驾驶证，或其他身份识别信息 (2) 带照片的学校身份卡，(3) 美国军人证或入伍记录，(4) 联邦、州或当地政府颁发的 ID 卡，当中的信息与驾驶证中的信息相同。

移民身份：下面是美国公民及移民服务局 (USCIS) 签发的文件

- I-551 永久居民卡 (绿卡)
- I-688B 或 I-766 就业授权卡
- I-94 出入境记录
- I-797 (行动通知) 或者与 USCIS、ICE 或 EIOR 之间来往的正式通信

托儿服口/被抚养人照护：文件必须包含您支付的金额和频率

- 日托中心或其他儿童/成人照护服务提供者的信函
- 证明照护服务费的已兑现支票或收据

孕：

- 有预期分娩日期的医生/医疗专业机构声明

私人健康保：文件必须包含您支付的金额

- 保险单
- 保险证明
- 保险卡
- 其他私人保险证明

除证明国籍或身份的文件外，我们接受所有文件的影印本。

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying to renew Medicaid and/or Family Planning Benefit Program coverage.

I understand that I must provide the information needed to prove my eligibility for each program. I agree to immediately report any changes to the information on this form. If I am unable to get the information, I will tell the social services district. The social services district may be able to help in getting the information.

I understand that workers from the programs for which family members or I are renewing may check the information given by me on 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.

I understand that Medicaid and/or Family Planning Benefit Program coverage will not pay medical expenses that insurance or another person is supposed to pay, and that I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.

I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. 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, disability or citizenship status may be a factor in whether or not I am eligible.

I understand that if my child is on Medicaid, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program.

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.

CERTIFICATION OF CITIZENSHIP/IMMIGRATION STATUS I certify under penalty of perjury, by signing my name on this form, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. The term "satisfactory immigration status" means an immigration status that does not make the person ineligible for benefits. **Important Information:** The United States Citizenship and Immigration Services (USCIS) has said that enrollment in Medicaid CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member or travel in and out of the country (except if Medicaid pays for long term care in a place like a nursing home or psychiatric hospital). **The State will not report any information on this application to the USCIS.**

SOCIAL SECURITY NUMBER All applicants must provide a social security number or proof that they have applied for one or tried to apply for one. The only exceptions are pregnant women, undocumented immigrants and temporary non-immigrants applying for the treatment of an emergency medical condition, and certain battered immigrants. SSNs are not required for members of my household who are not applying for benefits. 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. SSNs are used in many ways, both within Department of Social Services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient.

RELEASE OF MEDICAL INFORMATION I consent to the release of any medical information about me and any members of my family for whom I can give consent: by my Primary Care Provider, any other 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; by my health plan and any health care providers to SDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid; and, 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. If more than one adult in the family is joining a Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

MEDICAID MANAGED CARE If I am adding a family member to a Medicaid case and I live in a county that requires Medicaid recipients to join a health plan, I understand that this family member will be enrolled in the same health plan as my family, unless he or she is exempt or excluded.

RELEASE OF EDUCATIONAL RECORDS 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 reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.

EARLY INTERVENTION PROGRAM If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local Department of Social Services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid. I consent to sharing this information with any school-based health center that provides services to the applicant(s).

条款、权利与义务

填写并签署本表，即代表本人申请 Medicaid 和/或 Family Planning Benefit Program 给付续期。

本人了解，本人须提供所需信息，以证明本人有资格获得每项计划。本人同意，一旦此表中的信息有任何变更，本人会立即报告。如果本人无法获得信息，本人将告知社会服务区。社会服务区或许能帮助本人获得信息。

本人了解，本人家人或本人申请续期之计划的员工可能会检查本人在此表中提供的信息。执行这些计划的机构将根据 42 U.S.C. 1396a (a) (7)、42 CFR 431.300-431.307 以及任何联邦/州法律和法规来对这些信息予以保密。

本人了解，Medicaid 和/或 Family Planning Benefit Program 给付不会支付应由保险或他人支付的医疗费用，且在本人接受福利的整个期间，本人全权委托该机构向配偶或未满 21 岁者之父母要求并获得其医疗支持，也全权委托该机构要求并获得第三方付款。

本人会针对本人有权享受的健康或意外保险福利或者其他任何资源提出理赔。本人了解，如果使用健康保险可能损害本人或本人负法律责任之人的健康或安全，本人有权以正当理由拒绝配合使用健康保险。

本人了解，本人获得这些计划的资格不受本人种族、肤色或原国籍的影响。本人亦了解，根据各计划的要求，本人的年龄、性别、伤残状况或公民身份可能会影响本人的资格。

本人了解，如果本人子女参与 Medicaid，他或她能够获得综合的初级和预防性护理，包括儿童/青少年健康计划 (Child/Teen Health Program) 提供的所有必要治疗。

本人了解，任何人为获取上述计划的服务而故意撒谎或隐瞒真相，均属于犯罪行为，并将遭致联邦和州惩罚，还需要返还已领取的福利金，同时缴纳民事罚款。纽约州税务和财政部 (Department of Tax and Finance) 有权查看此表中的收入信息。

公民身份/移民身份证书 本人在此依据伪证惩罚条例保证，签署本表，即代表本人和/或本人代表签名之人是美国公民或国民或者拥有合适的移民身份。“合适的移民身份”一词是指让某人具有资格获得福利的移民身份。**重要信息：**美国公民和移民服务 (United States Citizenship and Immigration Services, USCIS) 表示，注册加入 Medicaid 不会影响获得绿卡、成为公民、资助家庭成员或在国内外旅行的资格 (Medicaid 支付疗养院或精神病院等的长期护理费用除外)。**州政府将不会向 USCIS 报告本申请中的任何信息。**

社会安全号码 所有申请人均须提供社会安全号码，或证明其已申请或已尝试申请。唯一例外是孕妇、无证移民、申请医疗紧急情况治疗的临时非移民和某些受虐移民。如果本人家庭成员不申请社会福利，则无需提供其相应的 SSN。本人了解，这是 42 U.S.C. 1320b-7 (a) 联邦法律和 42 CFR 435.910 中 Medicaid 规定的要求。许多方面都要使用 SSN，包括社会服务局 (Department of Social Services, DSS) 内部和 DSS 与联邦、州和纽约及其他辖区的当地机构之间。SSN 的使用包括：核实身份，确定并验证劳动所得和非劳动所得，了解非监护权的家长是否能为申请人投保医疗保险，了解申请人是否能获得医疗费用的资助，以及了解申请人是否能获得资金或其他支持。SSN 还可用于确定中央政府 Medicaid 机构内和之间的领取人，以确保向领取人提供适当的服务。

披露医疗信息 本人同意披露有关本人和本人可以代表同意的任何家庭成员的任何医疗信息：根据健康计划或提供者进行治疗、付款或健康护理操作的合理需求，通过初级保健提供者、任何其他健康护理提供者或纽约州卫生署 (New York State Department of Health, SDOH) 向本人的健康计划和涉及护理本人或本人家庭的任何健康护理提供者披露本人的医疗信息；出于管理 Medicaid 的目的，通过本人的健康计划和任何健康护理提供者向 SDOH 以及其他授权的联邦、州和当地机构披露本人的医疗信息；根据健康计划为进行治疗、付款或健康护理操作的合理需求，通过本人的健康计划向其他个人或组织披露本人的医疗信息。本人亦同意，在法律允许的范围内，所披露的信息可能包括本人和本人家庭成员的 HIV、心理健康或酒精和药物滥用信息。如果家庭中有一名以上成年人加入 Medicaid 健康计划，则同意披露信息需要每名申请 Medicaid 健康计划的成年人签名。

MEDICAID 管理式护理 如果本人将家庭成员加入 Medicaid 个案，并且本人居住的郡县要求 Medicaid 领用人参加健康计划，本人了解，此家庭成员将加入与本人家庭相同的健康计划，除非他或她被免除或排除在计划之外。

披露教育记录 本人授权当地社会服务局和纽约州获取有关本人子女教育记录的任何信息，以便申请健康相关教育服务的 Medicaid 报销，并允许联邦政府机构仅出于审计目的而适当获取这些信息。

早期干预计划 出于向 Medicaid 收款的目的，如果本人子女正接受纽约州早期干预计划的评估或者参与了该计划，本人允许当地社会服务局和纽约州与本郡县早期干预计划分享有关本人子女 Medicaid 资格的信息。本人同意将这些信息分享给为申请人提供服务的任何学校型健康中心。

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

The New York Medicaid program must tell you how we use, share, and protect your health information. The New York Medicaid program includes regular Medicaid and Medicaid Managed Care. The program is administered by the New York State Department of Health and the Local Departments of Social Services.

Your Health Information is Private.

We are required to keep your information private, share your information only when we need to, and follow the privacy practices in this notice. We must make special efforts to protect the names of people who get HIV/AIDS or drug and alcohol services.

What Health Information Does the New York Medicaid Program Have?

When you applied for Medicaid, you may have provided us with information about your health. When your doctors, clinics, hospitals, managed care plans and other health care providers send in claims for payment, we also get information about your health, treatments, and medications.

How Does the New York Medicaid Program Use and Share Your Health Information?

We must share your health information when:

- **You or your representative requests your health information.**
- **Government agencies request the information as allowed by law such as audits.**
- **The law requires us to share your information.**

In your Medicaid application, you gave the New York Medicaid Program the right to use and share your health information to pay for your health care and operate the program. For example, we use and share your information to:

- **Pay your doctor, hospital, and/or health care provider bills.**
- **Make sure you receive quality health care and that all the rules and laws have been followed.**

We may review your health information:

- **To determine whether you received the correct medical procedure or health care equipment.**
- **Contact you about important changes in your health benefits.**
- **Make sure you are enrolled in the right health program.**
- **Collect payment from other insurance companies.**
- **To determine eligibility in Medicare Part D or other insurance programs that might be more economical to you.**

We may also use and share your health information under limited circumstances to:

- **Study health care.** We may look at the health information of many consumers to find ways to provide better health care.
- **Prevent or respond to serious health or safety problems for you or your community as allowed by federal and state law.**

Your written authorization is required for other uses and disclosures:

- **Psychotherapy notes**
- **Uses and disclosures of Protected Health Information for marketing purposes, including subsidized treatment communications**
- **Disclosures that constitute a sale of your Protected Health Information.**

We must have your written permission to use or share your health information for any purpose not mentioned in this notice unless we are required to do so by the laws that apply to us.

What Are Your Rights?

You or your representatives have the right to:

- Get a paper copy of this notice.
- See or get a copy of your health information. If your request is denied, you have the right to review the denial.
- Ask to change your health information. We will look at all requests, but cannot change bills sent by your doctor, clinic, hospital or other health care provider.
- Ask to limit how we use and share your information. We will look at all requests, but do not have to agree to what you ask except where required by law to make such a disclosure.
- Ask us to contact you regarding your health care information in different ways (for example, you can ask us to send your mail to a different address).
- Ask for special forms that you sign permitting us to share your health information with whomever you choose. You can take back your permission at any time, as long as the information has not already been shared.
- Get a list of those who received your health information. This list will not include health information requested by you or your representative, information used to operate the New York Medicaid Program or information given out for law enforcement purposes.
- Be notified upon a breach of any of your unsecured Protected Health Information.

See the New York City Human Resources Administration web site for an electronic copy of this notice (https://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/privacy_notice.pdf). You may also visit the New York State Department of Health web site to see an alternate version (https://www.health.ny.gov/health_care/medicaid/program/hipaa/noticepriveng.htm).

***You will not be penalized for filing a complaint. If we change the information in this notice, we will post the amended version on our website at:**

https://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/privacy_notice.pdf

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

隐私权通知



本通知说明了我们会如何使用和披露您的医疗信息，以及您如何获取此类信息。
请仔细阅读本通知。

纽约 Medicaid 计划必须告知您我们如何使用、分享和保护您的健康信息。纽约 Medicaid 计划包括常规 Medicaid 和 Medicaid Managed Care。本计划由纽约州卫生署 (New York State Department of Health) 和当地社会服务局 (Local Departments of Social Services) 负责管理。

您的健康信息属于隐私信息。

我们必须让您的信息保持私密，仅在必要时分享您的信息并遵循本通知中的隐私管理做法。我们必须采取特殊措施，以保护获取艾滋病 (HIV/AIDS) 或药物和酒精相关服务的人员的姓名。

纽约 Medicaid 计划持有哪些健康信息？

在申请 Medicaid 时，您可能向我们提供了您的健康信息。当您的医生、诊所、医院、管理式医疗计划和其他医疗保健提供者提交付款请求时，我们也会获得关于您的健康、治疗和用药的信息。

纽约 Medicaid 计划会如何使用和分享您的健康信息？

我们必须在下列情况下分享您的个人信息：

- 您或您的代表索要您的健康信息。
- 政府机构在法律允许的情况下（例如审计）索要您的健康信息。
- 法律要求我们分享您的信息。

您申请 Medicaid 即表示您授权纽约 Medicaid 计划为支付医疗费和运营该计划而使用和分享您的健康信息。例如，我们可以出于下列目的而使用和分享您的信息：

- 支付您的医生、医院和/或医疗服务提供者的账单。
- 确保您能够获得高质量的医疗服务并且遵守一切相关法律和法规。

我们可能会审查您的健康信息：

- 以确定您是否已经获得适合的医疗程序或医疗设备。
- 以与您联系，告知您关于健康福利方面的重要变更。
- 以确保您已投保正确的健康计划。
- 以向其他保险公司收款。
- 以确定您是否有资格投保 Medicare 处方药物计划或其他对您来说更为经济的保险计划。

我们还会在有限的情况下出于下列目的分享和使用您的健康信息：

- **医疗护理研究。**我们会研究许多消费者的健康信息，以便找到改善医疗服务的方法。
- **在联邦和州法律允许的情况下预防或应对您或您的社区面临的重大健康或安全问题。**

如需在其他情况下使用和披露您的健康信息，则需要您的书面授权，这些情况包括：

- **心理治疗笔记**
- **出于营销目的而使用和披露受保护健康信息，包括补贴治疗沟通**
- **构成出售您受保护健康信息的披露行为。**

如果我们为了任何本通知未提及的用途而需要使用或分享您的健康信息，我们必须获得您的书面许可，除非适用法律要求我们必须使用或分享您的健康信息。

您有哪些权利？

您或您的代表有权：

- 获取本通知的纸质版副本。
- 查看或复制您的健康信息。如果您的要求被拒绝，您有权查看拒绝理由。
- 要求变更您的健康信息。我们会查看全部要求，但无法变更您的医生、诊所、医院或其他医疗服务提供者发送的账单。
- 要求限制我们使用和分享您信息的方式。我们会查看全部要求，但不一定满足您提出的要求，除非法律要求我们必须披露此类信息。
- 要求我们以不同的方式与您联系，沟通与您的医疗信息相关的事宜（例如，您可以要求我们将邮件发送到不同的地址）。
- 索要特殊表格，您可以通过签署该表格许可我们向您指定的任何人分享您的健康信息。只要我们尚未分享上述信息，您随时可以收回您的许可。
- 获取接收您的健康信息的人员列表。本列表不包含您或您的代表索要的健康信息、用于运营纽约 Medicaid 计划的信息或为配合执法而提供的信息。
- 要求我们在您未受保护的的健康信息泄露时通知您。

请访问纽约市人力资源管理局 (New York City Human Resources Administration) 网站获取本通知的电子版 (https://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/privacy_notice.pdf)。您也可以访问纽约州卫生署 (New York State Department of Health) 网站查看替代版本 (https://www.health.ny.gov/health_care/medicaid/program/hipaa/noticepriveng.htm)。

***您不会因提交投诉而受到处罚。如果本通知发生任何变更，我们会在网站上发布修订版本：**

https://www1.nyc.gov/assets/hra/downloads/pdf/services/micsa/privacy_notice.pdf

您是否有**医疗或心理健康疾病或残障问题**？此问题是否让您难以理解本通知或完成本通知所要求的情况？此问题是否使您难以获得 HRA 提供的其他服务？我们可助您一臂之力。致电 212-331-4640 联系我们。您也可以造访 HRA 办公室时寻求帮助。根据法律规定，您有权要求此类帮助。