Looking for a stress-free process to qualify for Medicaid benefits?

Put your mind at ease and let KTS take care of the details with all your best interests at heart

KTS Pooled Trust helps people meet their income eligibility requirements to receive Medicaid in-home care benefits. Joining KTS is an invaluable alternative to paying your excess income directly to Medicaid or your managed long-term care plan on a monthly basis. KTS will help you throughout the entire application process.

KTS Features

Funds available for use up to 90 days after passing

Reliable and responsive customer service — always a LIVE representative available to answer your calls and emails

Same day disbursement and electronic bill payment

24/7 online and phone access to check your recent balance and transactions

Competitive and flexible fees

Debit card available for members to help with spending flexibility

4.9 ★★★★★ | We are extremely proud of all of our positive Google reviews

Our team takes extra steps to ensure you receive the care and attention you deserve. It's not by accident that KTS has a reputation for taking exceptional care of its members.

KEEP THEM SAFE POOLED TRUST kts

718.475.5000 • ktstrust.org

Carlos Nath • ext 401 • carlos@ktstrust.org

Kristina Martel • ext 402 • kristina@ktstrust.org

KEEP THEM SAFE POOLED TRUST kts

ktstrust.org

D **Doron**
★★★★★

Staff are great to work with: efficient and dependable and can be counted on to keep the interests of my elderly relative in mind.

Posted on Google

R **Rachele Nicoletti**
★★★★★

The process works very smoothly each month and has freed up much needed time to be devoted to my parents. Highly recommend!

Posted on Google

D **Del Jones**
★★★★★

They are transparent and I love that I have access to my account at all times. I truly love this place.

Posted on Google

J **Jayne Porcelli**
★★★★★

Incredibly helpful in helping us use our resources for mom in the best way possible.

Posted on Google

R **Ray Malone**
★★★★★

The annual and monthly fee is minimal compared to the out-of-pocket expenses we would have had without medicaid.

Posted on Google

C **Charlotte Jones**
★★★★★

I feel less hassle keeping mom's bills organized. She and I feel safer for this and worries are eased.

Posted on Google

4.9 ★★★★★

We are exceptionally proud of our over 600 Google reviews with a 4.9 rating.

KEEP THEM SAFE POOLED TRUST

JOINDER AGREEMENT

3011 AVENUE K
BROOKLYN, NY 11210
718.475.5000
members@ktstrust.org

KTS POOLED INCOME TRUST

SUPPLEMENTAL NEEDS TRUST

JOINDER AGREEMENT

NOTE: THIS IS A LEGAL DOCUMENT. IT IS AN AGREEMENT PERTAINING TO A SUPPLEMENTAL NEEDS TRUST CREATED PURSUANT TO 42 UNITED STATES CODE §1396. YOU ARE ENCOURAGED TO SEEK INDEPENDENT, PROFESSIONAL ADVICE BEFORE SIGNING THIS AGREEMENT.

The undersigned hereby adopts, enrolls in and establishes a sub-trust account under the **KEEP THEM SAFE POOLED TRUST I,** dated, July 17th, 2013, and as amended hereafter ("**KTS POOLED TRUST I**") or the ("Trust").

1 | Beneficiary Information

Name

_____ _____ _____

First *Middle* *Last*

Marital Status ☐ *Married* ☐ *Widowed* ☐ *Single* **Gender** _____

_____–_____–_____ _____/_____/_____ _____

Social Security Number *Date of Birth* *Citizenship*

Contact Information

_____ _____

Home Phone *Cell Phone*

Preferred Phone ☐ *Cell* ☐ *Home*

_____

Email

Address

_____ _____ _____ _____ _____

Address *Apt#* *City* *State* *Zip*

Please list qualified disabilities

_____

_____

2 | Authorized Representative(s)

Who will be your primary contact? ☐ *Beneficiary* ☐ *Auth. Rep. 1* ☐ *Auth. Rep. 2*

Authorized Representative #1

_____ _____

First *Last*

Contact Information

_____ _____ **Preferred Phone** ☐ *Cell* ☐ *Home*

Home Phone *Cell Phone*

_____ **Relationship to Beneficiary**_____

Email

Address

_____ _____ _____ _____ _____

Address *Apt#* *City* *State* *Zip*

Authorized Representative #2

_____ _____

First *Last*

Contact Information

_____ _____ **Preferred Phone** ☐ *Cell* ☐ *Home*

Home Phone *Cell Phone*

_____ **Relationship to Beneficiary**_____

Email

Address

_____ _____ _____ _____ _____

Address *Apt#* *City* *State* *Zip*

3 | Medicaid Information

	Applicant	Spouse
Medicaid Status	☐ *Pending* ☐ *Accepted*	☐ *Pending* ☐ *Accepted*
Medicaid Number		
Monthly Surplus	**$**	**$**
	Single Applicant Surplus	*Combined Surplus*

If the Spouse applied with the trust beneficiary, please attach a copy of the joint budget letter or application.

Name of Spouse

_____ _____

First *Last*

What is the name of the MLTC or home care agency providing services, if any?

_____

4 | Household Income

Please indicate income by monthly amount.

INCOME SOURCE	PRIMARY APPLICANT	SPOUSE
Supplemental Security Income (SSI)	**$**	**$**
Social Security Disability Income (SSDI)	**$**	**$**
Social Security Retirement Income (SSA)	**$**	**$**
VA Benefits	**$**	**$**
Employments Benefits	**$**	**$**
IRA Distribution	**$**	**$**
401k, 403b, etc. Distribution	**$**	**$**
Pensions / Annuities	**$**	**$**
Interest / Dividends	**$**	**$**
Other: At Request Of HRA	**$**	**$**
Other: _____	**$**	**$**
Other: _____	**$**	**$**

5 | Power of Attorney (POA) Information

Please attach a copy of the Power of Attorney with this Joinder Agreement.

Does the Beneficiary have a designated Power of Attorney (POA)? ☐ *Yes* ☐ *No*

If you answered yes, continue to fill out below:

Designated Power of Attorney Information

_____ _____

First *Last*

_____ _____

Primary Phone *Email*

Is this person the sole POA? ☐ *Yes* ☐ *No*

If no, are the agents authorized to act separately? ☐ *Yes* ☐ *No*

6 | Guardian Information

Please attach a copy of the guardianship order with this Joinder Agreement.

Does the Beneficiary have a court appointed Guardian? ☐ *Yes* ☐ *No*

If you answered yes, continue to fill out below:

Guardian of the: ☐ *Person* ☐ *Property* ☐ *Both*

Court Appointed Guardian Information

_____ _____

First *Last*

_____ _____

Primary Phone *Email*

7 | Funeral Information

Does the Beneficiary have any funeral provisions in place? ☐ *Yes* ☐ *No*

If you answered yes, please attach funeral provision documents.

8 | Life Insurance Premium Information

Is there a life insurance policy in place for the Beneficiary? ☐ *Yes* ☐ *No*

If you answered yes, please attach life insurance documents.

9 | Health Insurance Premium Information

Medicare Part ☐ *B* ☐ *D* **Does the applicant have a supplemental policy?** ☐ *Yes* ☐ *No*

If yes, what is the monthly premium? $_____ Plan Name? _____

10 | Referring Source

Name of Agency or Firm: _____

Contact Information

_____ _____

First *Last*

_____ _____ _____ _____ _____

Address *Apt#* *City* *State* *Zip*

_____ _____

Phone *Email*

11 | Terms of Pooled Trust Agreement

1. Fee Information

Fees shall be paid in accordance with the published fee schedule and shall be incurred until the account is terminated and the funds are completely disbursed.

2. Death of Beneficiary

A. The Beneficiary's sub-trust account terminates upon his or her death. If, upon the death of the Beneficiary, funds remain in his or her sub-trust account, such funds shall be deemed to be property of the Trust and all funds that are remaining in the Beneficiary's separate sub-trust account shall be retained by the **KTS POOLED TRUST I** to benefit persons with disabilities.

B. All final disbursement requests must be submitted within ninety (90) days of the Beneficiary's death and upon submission of the death certificate. Only expenses incurred prior to the Beneficiary's death will be considered.

C. Funeral expenses will only be paid pursuant to a Medicaid eligible pre-need funeral agreement established prior to the Beneficiary's death. **Funeral expenses will not be paid after the Beneficiary's death.**

D. The Beneficiary's Authorized Representative shall notify **KTS POOLED TRUST I** upon the Beneficiary's death and send a certified copy of the Beneficiary's death certificate.

9. BY SIGNING BELOW, YOU EXPRESSLY CONFIRM THAT YOU HAVE REVIEWED THE ABOVE TERMS AND AGREE TO THE FOLLOWING REPRESENTATIONS:

A. Trust Documents: I have received and reviewed a copy of the **KTS POOLED TRUST I** Declaration of Master Trust, prior to the signing of this *Joinder Agreement*. I have also read the Information and Procedures and acknowledge that I understand the contents of all of the trust documents. I also understand that said documents may be amended from time to time.

B. Conflict of Interest: I am aware of the potential conflicts of interest that exist in the Trustee's administration of the Trust and I expressly waive any and all claims against the Trustees, the Trust and KEEP THEM SAFE FOUNDATION INC., or any affiliated entity for any act of self-dealing or conflict of interest resulting from the administration of the **KTS POOLED TRUST I.**

C. Taxes: I acknowledge that contributions to the **KTS POOLED TRUST I** are not tax deductible as charitable gifts, or otherwise.

D. Disability: I confirm that the Beneficiary is disabled as defined in Social Security Law Section 1614 (a) (3) [42 USC 13822(c) (a) (3)].

E. Additional Representations: I am also expressly aware of the following:

3. Contributions/Deposits

A. All contributions made to the Trust Account will be held and administered pursuant to the provisions of the **KTS POOLED TRUST I**. The provisions of the **KTS POOLED TRUST I** are incorporated herein by reference. The Beneficiary confirms that he or she has knowledge of the **KTS POOLED TRUST I** and assents to its terms.

B. The Trustees shall have the sole and absolute right to accept or refuse additional deposits to the Sub-trust account.

C. Please be advised that the Trustee may continue to charge administrative fees for the management of the sub-trust account prior until its closure. In the event that a Beneficiary wishes to re-open a sub-trust account, the Beneficiary may be required to pay any outstanding administrative fees stemming from the prior sub-trust account.

4. Disbursements

A. All disbursement requests shall be reviewed and approved on an individual basis.

B. Disbursements for expenses incurred prior to 90 days of submission of a disbursement request form shall not be paid.

C. All disbursements shall be made at the sole and absolute discretion of the Trustees.

D. All disbursements must be for the sole benefit of the Beneficiary.

5. Amendments

Provisions of this Joinder Agreement may be amended by both of the parties hereto **in writing, so long as any such amendment is consistent with the KTS POOLED TRUST I.**

6. Disclosure of Potential Conflict of Interest

There may be a potential conflict of interest in the administration of the Trust since the Trust retains any funds remaining in the sub-trust account at the time of death of the Beneficiary. Furthermore, Trust funds may be used to pay for ancillary and/or supplemental services for Beneficiaries and potential Beneficiaries for which services may be rendered by KEEP THEM SAFE FOUNDATION INC., the entity which established and appoints the Trustees of the Trust.

7. Applicable Law

The validity, construction, and all rights under this Agreement shall be governed by the laws of the State of New York.

8. Invalidity of any Provision

Should any provision of this Agreement be or become invalid or unenforceable, the remaining provisions of this Agreement shall be and continue to be fully effective.

The **KTS POOLED TRUST I** is a trust authorized to be used by individuals with disabilities pursuant to federal and state law. By agreeing to accept property pursuant to this Joinder Agreement, **KTS POOLED TRUST I**, agrees only to manage the trust funds in accordance with the terms of the Master Trust Agreement and in compliance with applicable federal and state law and regulation.

It is the sole responsibility of the Beneficiary and/or the Beneficiary's representative to determine whether the Beneficiary is "disabled" as that term is defined under federal law, to determine whether the transferor has the legal authority to transfer property to fund the trust, and the impact that a transfer of property to the **KTS POOLED TRUST I** will have on the Beneficiary's continuing eligibility for government benefit programs.

KTS POOLED TRUST I is not assuming any responsibility as counsel for the Beneficiary or the Beneficiary's representative or for providing any legal advice as it relates to the consequences of a transfer of property to the **KTS POOLED TRUST I**. **KTS POOLED TRUST I also assumes no responsibility for the eligibility of the Beneficiary to any public benefit program. KTS POOLED TRUST I** is also not responsible for the actions or non-actions of an Authorized Representative selected in paragraph 7 of this agreement or any other appointed representative of the Beneficiary.

The Trustees in their discretion may require an intermediary to assist in the administration of the Beneficiary's sub-trust account, the cost of which would be charged to that Beneficiary's sub-trust account.

An individual requesting and/or receiving disbursements in contravention of the Master Trust Agreement and the Joinder Agreement will be required to repay the amount disbursed.

This Joinder Agreement and the participation of the Beneficiary in the KTS POOLED TRUST I is an important legal decision that will have significant and lasting consequences for the Beneficiary and as a result you may want to consider obtaining advice from an attorney or another trusted professional adviser before entering into this Agreement.

I acknowledge that I have had a full and complete opportunity to confer with an attorney or other adviser and that no employee of KTS POOLED TRUST I has provided me (or the Beneficiary, if different from the person signing this Agreement) with any legal advice in connection with this Joinder Agreement, the participation by the Beneficiary in the KTS POOLED TRUST I or the suitability of such participation by the Beneficiary in the KTS POOLED TRUST I based upon the particular circumstances of the Beneficiary.

Under penalty of perjury, I affirm that all statements made in this document are true and accurate to the best of my knowledge.

12 | AGREEMENT SIGNATURE

Who is signing this Joinder Agreement? ☐ *Beneficiary* ☐ *Power of Attorney* ☐ *Guardian*

_____ _____ _____/_____/_____

Print Name *Sign* *Date*

13a | SIGNATURE OF NOTARY

STATE OF_____

COUNTY OF _____

On _____, **20**_____ before me, the undersigned, a Notary Public in and for said State, personally appeared,

_____,

personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledge to me that he/she/they executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed this instrument.

_____

Signature of Notary

13b | OR SIGNATURE OF TWO WITNESSES

WITNESS 1 ___/___/_____ *Date Witnessed*

_____

Print Name

_____

Signature

_____

_____

Address

WITNESS 2 ___/___/_____ *Date Witnessed*

_____

Print Name

_____

Signature

_____

_____

Address

14 | FOR OFFICE USE ONLY

_____ _____/_____/_____

KTS POOLED TRUST, I, as Trustee ***Date***

KEEP THEM SAFE POOLED TRUST

www.ktstrust.org

3011 AVENUE K
BROOKLYN, NY 11210

P 718.475.5000
F 718.475.5010
E members@ktstrust.org

Direct Debit (ACH) Authorization Form

☐ **NEW REQUEST**

☐ **CHANGE REQUEST**
- ☐ AMOUNT
- ☐ DATE
- ☐ BANK ACCOUNT

Name_____

KTS Account #_____

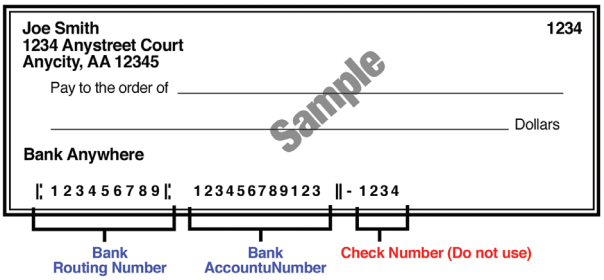
Bank Name _____

Routing # (9 Digits) ____ ____ ____-____ ____ ____-____ ____ ____

Bank Account #_____

☐ Checking ☐ Savings

☐ *Account number is the same as previous ACH form.*



Debit Amount: $_____ ☐ Monthly ☐ One Time

Month to Start Debits: _____

Date for Monthly Debits: _____ *(Choose which day of the month your debit will occur.)*

☐ Debit One Time Enrollment Fee of $250

By signing this form I authorize KTS Pooled Trust to debit the amount stated on or around the date I indicated each month or immediately for a one time debit. I understand that it could take up to 3 days for the ACH to fully process and that I will have access to the funds only after the funds have fully cleared. I also agree to pay any fee that might result in a returned ACH. This authorization is to remain in full force and effect until KTS receives written notification from me of its termination in such time and manner to afford KTS a reasonable amount of time to act on it.

SIGNATURE OF BANK ACCOUNT HOLDER _____Date _____

ATTACH VOIDED CHECK HERE

Please Email, Fax, or Mail this completed form to the KTS Pooled Trust office.

KEEP THEM SAFE POOLED TRUST kts
www.ktstrust.org

3011 AVENUE K
BROOKLYN, NY 11210

P 718.475.5000
F 718.475.5010
E info@ktstrust.org

KTS Pooled Trust Fees

- A one-time enrollment fee of $250 will be charged to establish your trust account.

- An administrative fee will be deducted from your trust account each month. The administrative fee will be 10% of your monthly Medicaid surplus deposit. This fee will be a minimum of $30 and a maximum of $200.

- An annual renewal fee of $100 with be deducted from your trust account one year from the date your trust was established, and each subsequent year.

- A returned check or ACH/Direct Debit fee of $25 will be deducted from your trust account in the event that a payment is returned due to insufficient funds, etc.

KEEP THEM SAFE POOLED TRUST
www.ktstrust.org

3011 AVENUE K
BROOKLYN, NY 11210

P 718.475.5000
F 718.475.5010
E members@ktstrust.org

Instructions for Filing a Pooled Trust with Medicaid

Disability Determination Request MAP-3177: Complete member's information and signed by member and/or authorized representative.

Medical Report for Determination of Disability DOH-5143: To be completed and signed by the member's doctor.

Progress Notes: The doctor should also provide progress notes from the member's most recent visits, preferably within the last 60 days.

Disability Questionnaire DOH-5139: To be completed and signed by the member.

Authorization to Release Medical Information MAP-751E: To be completed and signed by the member. ("Source" is the doctor completing the LDSS-486T.)

Authorization for Release of Health Information HIPPA DOH5173: To be completed and signed by member. (Use sample HIPPA as a reference).

These forms should be submitted to Medicaid with the following documents after the trust has been approved and established.

- Approved Joinder Agreement
- Verification of deposit (VOD)
- Welcome letter

DISABILITY DETERMINATION REQUEST

Human Resources Administration
Department of Social Services

MAP-3177 (E) 01/14/2021

Date: _____

Case Name: _____

Case Number (if known): _____

If you have a disability determination from Social Security Administration (SSA), Supplemental Security Income (SSI) or Supplemental Security Income Disability (SSDI) **do not** submit this form.

First Name: _____ Last Name: _____ MI: _____

Mailing Address: _____ DOB: _____ Age: _____

_____

Phone Number: _____ SSN **(Last four Numbers only)**: _____

Please check (✓) the following boxes

Employed	☑ Yes	☐ No
Visually Impaired	☐ Yes	☐ No
Hearing Impaired (TTY)	☐ Yes	☐ No
Does A/R need a Medicaid waiver?	☐ Yes	☐ No

If **yes**, waiver type: _____

Language Spoken: _____ Language Written: _____

Authorized Representative (Person assisting you with the disability determination request):

First Name: _____ Last Name: _____ MI: _____

Mailing Address: _____ Phone Number: _____

_____

Authorized Representative may (check (✓) all that apply):

☐ Apply Renew Medicaid Application ☐ Discuss Medicaid Application/Case ☐ Receive Mail/Correspondence

Applicant/Recipient Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

NEW YORK STATE DEPARTMENT OF HEALTH
Disability Review Unit

Medical Report for Determination of Disability

Section I – Identification

Agency
State Disability Review Unit OCP-826
State of New York
Department of Health
Albany, NY 12237
Telephone Number: 1(866) 330-0591

Patient

Name (Last, First, Middle) _____

Address (Street, City, State & Zip Code): _____

_____

_____

Date of Birth ___/___/___

Sex ☐ Male ☐ Female

Case Number _____

Client ID Number _____

Disability ID Number _____

SSN (last four digits) _____

Section I – Medical Report – Note to Provider

This individual has made an application (reapplication) for Disability Medicaid. Your cooperation in completing this form to show the individual's current condition, focusing on both remaining capabilities and limitations, is requested. Your promptness will ensure an early decision on the individual's application.

Please return the completed form to the agency in Section I above, along with a copy of all medical records for the past 12 months.

Diagnosis(es) _____

_____

_____

Date of last exam _____

Height _____ ft. _____ in.

Weight _____ lbs.

Exertional Functions. Please indicate what the individual is CAPABLE of doing:

Lifting
- ☐ < 10 lbs.
- ☐ Max. 10 lbs.
- ☐ Max. 20 lbs./freq. 10 lbs.
- ☐ Max. 50 lbs./freq. 25 lbs.
- ☐ > 50 lbs.

Carrying
- ☐ < 10 lbs.
- ☐ Max. 10 lbs.
- ☐ Max. 20 lbs./freq. 10 lbs.
- ☐ Max. 50 lbs./freq. 25 lbs.
- ☐ > 50 lbs.

Standing
- ☐ < 2 hrs./day
- ☐ 2 hrs./day
- ☐ 6 hrs./day

Walking
- ☐ < 2 hrs./day
- ☐ 2 hrs./day
- ☐ 6 hrs./day

Sitting
- ☐ < 6 hrs./day
- ☐ 6 hrs./day

Pushing
- ☐ Using R arm
- ☐ Using L arm
- ☐ Using R leg
- ☐ Using L leg

Pulling
- ☐ Using R arm
- ☐ Using L arm

Non-Exertional Functions. Please check if LIMITATIONS exist in any of the areas below:

Sensory
- ☐ No Limitations
- ☐ Seeing
- ☐ Hearing
- ☐ Speaking

Postural
- ☐ No Limitations
- ☐ Stooping/Bending
- ☐ Crouching/Squatting
- ☐ Climbing

Manipulative
- ☐ No Limitations
- ☐ R Upper Extremity
- ☐ L Upper Extremity

Environmental
- ☐ No Limitations
- ☐ Tolerating dust, fumes, extremes of temperature
- ☐ Tolerating exposure to heights or machinery
- ☐ Operating a motor vehicle

Mental
- ☐ No Limitations
- ☐ Understanding, carrying out, remembering instructions
- ☐ Making simple work-related decisions
- ☐ Responding appropriately to supervision, co-workers, work situations
- ☐ Dealing with changes in a routine work setting

Provider Signature _____ Print Name _____ Date Signed _____

Specialty _____ Office Address _____ Office Phone Number _____

PLEASE RETURN THIS FORM **ALONG WITH A COPY OF ALL MEDICAL RECORDS FOR THE PAST 12 MONTHS.**

NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Disability Questionnaire

COMPLETED BY THE STATE DISABILITY REVIEW UNIT:

NAME:

First: _____

Middle: _____

Last: _____

Social Security Number (last 4 digits): _____

Date of Birth: _____

Telephone No: _____

Case Number: _____

Client ID Number (CIN): _____

Disability ID Number (DIN): _____

Medicaid application date: _____

Medicaid Waiver? ☐ Yes ☐ No

Waiver type: _____

Have you ever applied to the Social Security Administration (SSA) for disability benefits? ☐ Yes ☐ No

If "Yes", when? (month/year) _____ SSA decision date: (month/year) _____

What was the decision? _____

If denied for benefits, what was the reason (medical or non-medical)? _____

Did you appeal the decision? ☐ Yes ☐ No If "Yes", when? (month/year) _____

PART I – INFORMATION ABOUT YOUR MEDICAL CONDITIONS

A. Please list all of your medical conditions (diagnoses):

B. How do your medical conditions affect your ability to function? (Please include any limitations in your ability to perform activities of daily living and work-related activities.)

C. Please list your medications (or attach a list).

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

In order to make a disability determination, current medical evidence is needed to evaluate your physical and/or mental impairments. If you have not seen a medical provider for your impairment(s) within the past 12 months, a consultative exam may be arranged for you by the local agency.

A. Do you have a primary care provider? ☐ Yes ☐ No
(If "Yes", please provide name, address, phone number.)

Date of last visit (month/year): _____

B. Have you seen any other medical provider(s) within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name, address, and phone number of all medical providers you have seen for the past 12 months (for example physicians, nurse practitioners/physician assistants, mental health counselors, physical/occupational/speech therapists, audiologists, etc.). (Continuation sheets are available.)

Name:	Phone Number:	Address:
Reason for seeing:		
Name:	Phone Number:	Address:
Reason for seeing:		
Name:	Phone Number:	Address:
Reason for seeing:		

C. Have you received medical care in a hospital or other health care facility within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name and address of all hospitals and other medical facilities at which you have sought treatment in the past 12 months. (Continuation sheets are available.)

Name:	Address:
Reason:	
Name:	Address:
Reason:	
Name:	Address:
Reason:	

D. Have you received services from any agencies to assist you with your impairment(s) within the past 12 months? ☐ Yes ☐ No
(If "Yes", please complete the section below.)

Please list the name and address of any other agencies that you have seen for assistance with your medical conditions in the past 12 months (for example, vocational rehabilitation agencies, supported employment or housing agencies, case management agencies, etc.).

Name:	Address:
Reason:	
Name:	Address:
Reason:	
Name:	Address:
Reason:	

PART III – INFORMATION ABOUT YOUR EDUCATION AND LITERACY

If a disability determination cannot be made based on your medical conditions alone, the factors of education, literacy, and work history will be used to determine disability.

A. **What is the highest grade level of schooling that you have completed?** _____

B. If you have a child up to the age of 21 attending school or a vocational program, please provide the school or program's name and address.

School/Program Name: _____

Address: _____

_____

Please complete the DOH-5173, Authorization for Release of Medical Information Pursuant to HIPAA form for this school/program.

C. Were (are) you involved in Special Education classes in school? ☐ Yes ☐ No

D. Did (do) you receive any special help or accommodations in school? ☐ Yes ☐ No *(If "Yes", please describe.)*

(If you have a copy of your IEP, please include it with the returned forms.)

E. Have you received any vocational training or additional education within the past 12 months? ☐ Yes ☐ No
(If "Yes", please describe.)

F. Can you read a simple message in any language (such as simple instructions, or a list of items)? ☐ Yes ☐ No

G. Can you write a simple message in any language? ☐ Yes ☐ No

H. Was assistance or an interpreter necessary to complete this application? ☐ Yes ☐ No
(If "Yes", please indicate your primary language.)

PART IV – INFORMATION ABOUT WORK YOU DID IN THE PAST 15 YEARS

Have you worked in the past 15 years? ☐ Yes ☐ No

If YES, in as much detail as possible, please list jobs (up to 5) that you performed IN THE PAST 15 YEARS, starting with your most recent job.

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ____________ **To:** ____________	 **Number of hours/week:** ____________	 **Rate of Pay:** ____________
Describe your basic duties:		
During a typical day, how many hours did you: Stand ________ Walk ________ Sit ________		
How much did you frequently lift?________ pounds		
Reason for leaving:		

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ____________ **To:** ____________	 **Number of hours/week:** ____________	 **Rate of Pay:** ____________
Describe your basic duties:		
During a typical day, how many hours did you: Stand ________ Walk ________ Sit ________		
How much did you frequently lift?________ pounds		
Reason for leaving:		

Dates of Employment:	**Job Title:**	**Type of Business:**
From: ____________ **To:** ____________	 **Number of hours/week:** ____________	 **Rate of Pay:** ____________
Describe your basic duties:		
During a typical day, how many hours did you: Stand ________ Walk ________ Sit ________		
How much did you frequently lift?________ pounds		
Reason for leaving:		

PART IV

CONTINUED ON NEXT PAGE

PART IV – INFORMATION ABOUT WORK YOU DID IN THE PAST 15 YEARS

CONTINUED

Dates of Employment:	**Job Title:**	**Type of Business:**
From: _____		
To: _____	**Number of hours/week:** _____	**Rate of Pay:** _____
Describe your basic duties:		
During a typical day, how many hours did you: Stand _____ Walk _____ Sit _____		
How much did you frequently lift? _____ pounds		
Reason for leaving:		

Dates of Employment:	**Job Title:**	**Type of Business:**
From: _____		
To: _____	**Number of hours/week:** _____	**Rate of Pay:** _____
Describe your basic duties:		
During a typical day, how many hours did you: Stand _____ Walk _____ Sit _____		
How much did you frequently lift? _____ pounds		
Reason for leaving:		

Name of Person Completing Form (Please Print):	**Date:**
Telephone Number:	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NYC Human Resources Administration
Department of Social Services

MAP-751e (E) 06/06/2012

INFORMATION ABOUT MEDICAL OR OTHER SOURCE - PLEASE PRINT, TYPE, OR WRITE CLEARLY	
NAME AND ADRESS OF SOURCE (include Zip Code)	RELATIONSHIP TO DISABLED PERSON

INFORMATION ABOUT DISABLED PERSON - PLEASE PRINT, TYPE, OR WRITE CLEARLY		
NAME AND ADDRESS (if known) AT THE TIME DISABLED PERSON HAD CONTACT WITH SOURCE (Include Zip Code)	DATE OF BIRTH	DISABLED PERSON'S I.D. NUMBER (If known and if different than SSN.)
APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE (e.g., dates of hospital admission, treatment, discharges, etc.)		

I hereby authorize the above named source to release or disclose to the Medical Assistance Program for re-disclosure in connection with my application for public health insurance.

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care of my impairment(s), including psychological or psychiatric impairment(s) drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or test for infection with human immunodefiency virus (HIV).

2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living.

3) Information about how my impairment(s) affected my ability to do work.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end at the conclusion of any proceedings, administrative or judicial, in connection with my Medicaid application, including any appeals. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATION TO DISABLED PERSON (If other than self)	DATE
STREET ADDRESS	TELEPHONE NUMBER (include area code)	
CITY	STATE	ZIP CODE

NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name:	Date of Birth:	Social Security Number (Last four digits):
Address:	Client ID Number(CIN):	Disability ID Number(DIN):

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to Alcohol and Drug Abuse, Mental Health Treatment, except psychotherapy notes, and Confidential HIV Related Information, unless I check the appropriate box(es) in section 9(c). Otherwise, in the event the health information described below, in section 9(a), includes any of these types of information, and I initial the line on the box in section 9(b), I specifically authorize release of such information to the person(s) or entity indicated in Section 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (888) 392-3644 or TDD/TTY (718) 741-8300
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below in Section 7. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. If not previously revoked, this authorization will expire upon completion of this determination/review or one year from the date this form is signed, whichever comes first.
4. I understand that signing this authorization is voluntary. I understand that the State Disability Review Unit requires the completion of this form in order to gather health information necessary for a disability determination. I understand that without this authorization, my eligibility for Medicaid benefits may be affected.
5. Information disclosed under this authorization might be re-disclosed by the Department of Health (except as noted under item 2), and this re-disclosure may no longer be protected by federal or state law.
6. This authorization does not authorize you to discuss my health information or medical care with anyone other than the government agency specified in Section 9(b).

7. Name and address of the health provider or entity authorized to release this information:

8. Name and address of person(s) or agency to whom this information is to be sent:

9(a). Specific information to be released:

- ☐ Medical records from _____ (date) to _____ (date).
- ■ Entire Medical Record, including patient histories, office notes(except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

9(b). Authorization to discuss Health Information:

By initialing here _____ I authorize _____
(NAME OF INDIVIDUAL/HEALTH CARE PROVIDER)

to discuss my health information with the **State Disability Review Unit**.

9(c). I do not consent to the disclosure of (Check all boxes that apply): ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

10. Reason for release of information: ☐ At request of individual ☐ Other: At Request Of HRA

11. Purpose of the Use/Disclosure: **Disability Determination and Review**

12. If not the patient, name of the person signing this form (print):

13. Type of authority to sign on behalf of the patient:

All sections on this form have been completed and my questions about this form have been answered.
I authorize the facility/person noted on this page to release health information of the person named on this page to the New York State Department of Health State Disability Review Unit.

SIGNATURE OF THE PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

DATE

Instructions for Completing the Authorization for Release of Health Information Pursuant to HIPAA

The "Authorization for Release of Health Information and Confidential HIV-Related Information" form gives permission to your healthcare providers (hospitals, doctors, therapists, etc.) to send in copies of your health records to the State Disability Review Team. These health records will help the Disability Review Team determine if you are disabled. You will need to fill out and send one of these forms to every one of your healthcare providers that needs to send in your medical records.

The box at the top of the form will be filled in. If the information is incorrect, please put a line through what is incorrect and write in the correct information.

Read the information in items 1-6 found under the top box, before filling in the rest of the form. These paragraphs give you information on the type of health information that you can choose to be sent by your healthcare providers, your rights to authorize the release of your health records and how to stop the authorization, and who is allowed to see your health information.

7) Put the name and address of the healthcare provider who is to send your health records to the State Disability Review Team. **Fill out one form for each of your healthcare providers.**

8) Informs the healthcare provider to whom to send the health records. This box will be already filled in with the State Disability Review Team's information.

9a) • If you want the healthcare provider to send your medical records for a certain period of time, put a check in the first box and enter the dates for the time period. To make a disability determination, at least 12 months of health records are needed for the time period in which the disability is being determined.

• If you want the healthcare provider to send your entire medical record, put a check in the second box.

• If you want the healthcare provider to send in any other information, put a check in the third box (Other) and write the information that the healthcare provider is to send.

9b) If you want to allow your healthcare provider to speak with someone on the State Disability Review Team, put your initials and the name of your healthcare provider on the lines provided.

9c) Under 9(c), check the boxes for the type of medical information that your healthcare provider is not permitted to send.

10) Check the box if the individual requested the release of information, or check Other and state the reason for the request.

11) The purpose of this request is for a disability determination and review.

12) If you are not the patient filling out the form to request medical records, print your name.

13) If you are the legal representative of the patient, put the relationship you have to the patient. For example, if the patient is a child and you are the parent, put parent. If you are the legal guardian of the patient, put legal guardian.

If you want your healthcare provider to send your medical records, this form must be signed and dated by the patient or the patient's legal representative.

NEW YORK STATE DEPARTMENT OF HEALTH
State Disability Review Unit

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name:	Date of Birth:	Social Security Number (Last four digits):
Doe, John	01/01/1900	123-45-6789
Address:	**Client ID Number(CIN):**	**Disability ID Number(DIN):**
123 Main Street, Anytown, NY 12345		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to Alcohol and Drug Abuse, Mental Health Treatment, except psychotherapy notes, and Confidential HIV Related Information, unless I check the appropriate box(es) in section 9(c). Otherwise, in the event the health information described below, in section 9(a), includes any of these types of information, and I initial the line on the box in section 9(b), I specifically authorize release of such information to the person(s) or entity indicated in Section 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (888) 392-3644 or TDD/TTY (718) 741-8300
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below in Section 7. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. If not previously revoked, this authorization will expire upon completion of this determination/review or one year from the date this form is signed, whichever comes first.
4. I understand that signing this authorization is voluntary. I understand that the State Disability Review Unit requires the completion of this form in order to gather health information necessary for a disability determination. I understand that without this authorization, my eligibility for Medicaid benefits may be affected.
5. Information disclosed under this authorization might be re-disclosed by the Department of Health (except as noted under item 2), and this re-disclosure may no longer be protected by federal or state law.
6. This authorization does not authorize you to discuss my health information or medical care with anyone other than the government agency specified in Section 9(b).

7. Name and address of the health provider or entity authorized to release this information:

Dr Seuss - 456 Main Street, Anytown, NY 12345

8. Name and address of person(s) or agency to whom this information is to be sent:

Organization Submitting Trust to Medicaid - 789 Main Street, Anytown, NY 12345

9(a). Specific information to be released:

☐ Medical records from _____ (date) to _____ (date).

☐ Entire Medical Record, including patient histories, office notes(except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

9(b). Authorization to discuss Health Information:

By initialing here JD I authorize Dr. Seuss
(NAME OF INDIVIDUAL/HEALTH CARE PROVIDER)

to discuss my health information with the **State Disability Review Unit**.

9(c). I do not consent to the disclosure of (Check all boxes that apply): ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

10. Reason for release of information: ☐ At request of individual ■ Other: At request of HRA

11. Purpose of the Use/Disclosure: **Disability Determination and Review**

12. If not the patient, name of the person signing this form (print): At request of HRA

13. Type of authority to sign on behalf of the patient: At request of HRA

All sections on this form have been completed and my questions about this form have been answered.
I authorize the facility/person noted on this page to release health information of the person named on this page to the New York State Department of Health State Disability Review Unit.

SIGNATURE OF THE PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

DATE

Instructions for Completing the Authorization for Release of Health Information Pursuant to HIPAA

The "Authorization for Release of Health Information and Confidential HIV-Related Information" form gives permission to your healthcare providers (hospitals, doctors, therapists, etc.) to send in copies of your health records to the State Disability Review Team. These health records will help the Disability Review Team determine if you are disabled. You will need to fill out and send one of these forms to every one of your healthcare providers that needs to send in your medical records.

The box at the top of the form will be filled in. If the information is incorrect, please put a line through what is incorrect and write in the correct information.

Read the information in items 1-6 found under the top box, before filling in the rest of the form. These paragraphs give you information on the type of health information that you can choose to be sent by your healthcare providers, your rights to authorize the release of your health records and how to stop the authorization, and who is allowed to see your health information.

7) Put the name and address of the healthcare provider who is to send your health records to the State Disability Review Team. **Fill out one form for each of your healthcare providers.**

8) Informs the healthcare provider to whom to send the health records. This box will be already filled in with the State Disability Review Team's information.

9a) • If you want the healthcare provider to send your medical records for a certain period of time, put a check in the first box and enter the dates for the time period. To make a disability determination, at least 12 months of health records are needed for the time period in which the disability is being determined.

• If you want the healthcare provider to send your entire medical record, put a check in the second box.

• If you want the healthcare provider to send in any other information, put a check in the third box (Other) and write the information that the healthcare provider is to send.

9b) If you want to allow your healthcare provider to speak with someone on the State Disability Review Team, put your initials and the name of your healthcare provider on the lines provided.

9c) Under 9(c), check the boxes for the type of medical information that your healthcare provider is not permitted to send.

10) Check the box if the individual requested the release of information, or check Other and state the reason for the request.

11) The purpose of this request is for a disability determination and review.

12) If you are not the patient filling out the form to request medical records, print your name.

13) If you are the legal representative of the patient, put the relationship you have to the patient. For example, if the patient is a child and you are the parent, put parent. If you are the legal guardian of the patient, put legal guardian.

If you want your healthcare provider to send your medical records, this form must be signed and dated by the patient or the patient's legal representative.