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.
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.
如果您對於續保表格有任何疑問，同樣可以撥打 HRA Medicaid 服務專線 1-888-692-6116。您也可以聯絡列於隨附「續保申請表填寫指南」第 4 頁的其中一項管理式護理計畫。

這是自動發給您的唯一一份續保申請表。請於返還給我們之前妥善保管。我們必須在申請表上第 1 頁的印刷日期截止前收到您的郵件回覆，否則您的給付可能會終止。

您仍然可以在 Access NYC 站點預先篩選其他福利。您可以前往 http://www1.nyc.gov 並在位於頁面下方的選單中選擇 Social Services (社區服務)，來進行評估。此網站非常安全、有保障且易於使用。

備註：

- 您目前不需要遞交美國公民證明。除非續保表單要求這麼做，否則您也不需要寄送收入證明。
  - 如果您願意，你可以寄送前述一項或兩項資訊，以確保我們有您最準確的資訊。
  - 如果您決定目前不提供任何證明，我們往後可能會以書面向您提出要求。您可以查看本手冊第 5 頁和第 6 頁的『文件指南』，了解我們接受的證明類型。
- 如果您聲稱具有美國公民身分，我們將會使用電腦查核。如果我們查核無法確認屬實，將會以書面方式要求您提供證明。
- 我們也會嘗試使用電腦查核確認您的收入。如果查核結果與您自我申報的資訊有出入，查核結果將被用來判定您的資格。
  - 如果您決定目前不提供任何證明，我們往後可能會以書面向您提出要求。您可以查看本手冊第 5 頁和第 6 頁的『文件指南』，了解我們接受的證明類型。
- 如果您最近從紐約市搬到紐約州內的另一個郡，但尚未在現在居住的地方建立醫療保險個案，則應該填妥續保表單並寄給我們。我們會協助您轉承保。
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- **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**
  - 800-493-4647
  - (formerly AMERICHOICE BY UNITED/ AMERCHOICE OF NY INC.)
- **WELLCARE OF NY, INC.**
  - 800-308-2571
  - 800-215-1531

**MEDICAID RENEWAL SITE**
- 785 Atlantic Ave.
- Brooklyn, NY 11238
- 888-692-6116
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.

**Type of Proof**
- 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

**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

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

- I-551 Permanent Resident Card (Green Card)
- I-94 Arrival/Departure Record
- I-688B or 1-766 Employment Authorization Card
- 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**
以下是醫療補助計畫接受的證明文件清單。請查閱本指南和續保通知手冊封面上的說明，確認您需要提供哪些文件才能續保醫療保險。

### 收入:

#### 工資和薪資/雇傭
- 當前薪資單或薪資記錄
- 雇主提供的詳細書面明細表
- W-2 (僅限 MBI-WPD 客戶)
- 所得稅申報表 (僅限 MBI-WPD 客戶)

#### 工作收入
- 如果薪水維持不變 → 最近一份薪資單影本或雇主的證明信件。
- 如果薪水在每次支付期間有所變化 → 來自雇主的證明信件或是最近 4 週的薪資記錄影本。
- 如果您的薪資/收入的任何一部分是透過現金支付，且您的雇主不便提供書面證明 → 請於續保手冊第 2 頁收入區下方的第一個問題回答「是」。
- 如果為自雇 → 最近的納稅申報表和目前收入的信函 (由您簽名) 的影本。如果您的收入有變化，請解釋原因。
- 如果您收到失業救濟金 → 請寄送紐約州勞工部 (NYS Department of Labor) 的失業保險核准發放信函或由網路列印副本: [https://ui.labor.state.ny.us/UBC/home.do](https://ui.labor.state.ny.us/UBC/home.do)

#### 失業救濟金
- 核准發放信函/證明
- 救濟金聲明或列印影本
- 紐約州勞工部所發的信函

#### 兒童撫養費/贍養費
- 提供扶養者發出的信函或法院信函
- 兒童撫養/贍養費支票存根

#### 出租或膳宿的收入
- 房客、寄膳房客、租戶之信函
- 支票存根

#### 退伍軍人福利
- 核准發放信函
- 支福利票存根
- 退伍軍人管理局 (Veterans’ Administration) 來函

### 公民 (如果您宣稱是美國公民，您目前無需發送證明。如果需要證明文件，您將收到要求文件的信函。)
- 美國護照
- 美國公民證明
- 人籍證書
- 美國出生證明和下列證件之一以茲證明：(1) 包含照片或其它身分資訊的駕照 (2) 包含照片的學校證明卡，(3) 美國軍人卡或入伍記錄，(4) 由聯邦、州或地方政府簽發的 ID 卡，卡上的資訊與駕駛執照上的資訊相同。

### 移民身分：
- I-551 美國永久居留證（綠卡）
- I-94 出入境記錄
- I-688B 或 I-766 就業授權卡
- I-797（行動通知信）或與 USCIS、ICE 或 EIOR 的其他官方信函

### 托兒服務/被撫養人照護:
- 日托中心或其他兒童/成人護理提供者的信函
- 已兌現的支票或收據，可用來證明支付照護服務的款項

### 懷孕:
- 醫生/醫療專業人員的預計生產日期的聲明

### 私人健康保險:
- 保單
- 保険證明
- 保険卡
- 其他私人保險證明

除了證明公民身份或其他身份必須提供的文件外，我們接受其他所有文件的影本。
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).
填寫並簽署本表格，即代表本人申請 Medicaid 和/或 Family Planning Benefit Program 給付續期。

本人了解，申請人須提供證明所需資訊，以證明本人符合各項計畫的資格。本人同意，一旦本表格中的資訊有任何變動，本人均將立即回報。若本人無法取得相關資訊，則會告知社會服務區。社會服務區或許可幫助本人取得資訊。

本人了解，此人為申請續期之計畫的員工可能會檢查本表格中提供的資訊。執行這些計畫的機構會根據 42 U.S.C. 1396a (a) (7)、42 CFR 431.300-431.307 及任何聯邦及州立法律和法規來保密這項資訊。

本人會根據計畫有權享有之醫療或意外保險金或者其任何其他資質申請理賠。本人了解，倘使用醫藥保險可能對本人或本人須依法負責的對象之健康或安全構成傷害，本人同意妥善處理該醫療保險。

本人了解，本人加入此類計畫之資格不受種族、膚色或國籍影響。本人亦了解，根據個別計畫的規定，本人之年齡、性別、殘障身分或公民資格身分可能會影響本人符合資格與否。

我瞭解，如我的子女加入 Medicaid 計畫，他或她能夠獲得綜合的初級預防看護，包括透過兒童/青少年健康計畫 (Child/Teen Health Program) 的所有必要治療。

本人瞭解，凡為接受計畫服務而蓄意說謊或隱藏真相者，一律視為犯罪，除應接受聯邦及州之懲處，亦須歸還已領取之福利金，並繳納民事罰金。紐約州稅收與財政部 (New York State Department of Tax and Finance) 有權檢閱此表單上的收入資訊。

公民/移民身分證明：本人在此依據偽證懲處條例保證，簽署本表格，即代表本人和/或本人代表簽名之任何人為美國公民或國民或者具有合格移民身分之公民或國民。「合格移民身分」一詞代表不會致使此人失去福利資格的移民身分。重要資訊：美國公民和移民服務 (United States Citizenship and Immigration Services, USCIS) 表示，投保 Medicaid 並不會影響個人申請綠卡、成為公民、資助家人或國內外旅遊的能力（但 Medicaid 在療養院或精神病院等地方支付長期護理費用的情況除外）。本州不會向 USCIS 呈報本申請表中的任何資訊。

社會安全號碼：所有申請人皆須提供社會安全號碼，或須提供能夠證明其已申請或嘗試申請過社會安全號碼的證據。唯有申請緊急醫療的懷孕婦女、無證移民和臨時非移民例外。本人家庭中未申請福利金的成員不需提供 SSN。本人瞭解，這是聯邦法 42 U.S.C. 1320b-7 (a) 及 Medicaid 法規第 42 CFR 435.910 條的規定。無論是在紐約還是其他轄區，社會服務局 (Department of Social Services, DSS) 內部和 DSS 及聯邦、州與地方機構之間都會有許多情況需要用到 SSN。SSN 的用途包括：檢查身分，辨別和確認勞動收入和非勞動收入，確認非監護家長能否領取申請人的醫療保險給付，確認申請人能否得到醫療資助，以及確認申請人能否得到金錢或其他方面的協助。中央政府 Medicaid 機構內部和之間也會使用 SSN 辨別領用人身分，以利為領用人提供適當的服務。

醫療資訊披露：我同意披露我及我能夠同意的任何家庭成員有關的任何醫療資訊：由我的初級護理提供者、其他任何醫療保健提供者或紐約州衛生署 (State Department of Health, SDOH) 向照顧我及我家庭的計畫及任何醫療保健提供者披露，以便我的健康計畫或我的提供者能夠進行治療、付款或醫療作業：由我的健康計畫向其他人或組織披露，以便我的健康計畫進行治療、付款或醫療作業：我同意在法律許可的範圍內披露的資訊包括我和我的家庭成員有關的 HIV、心理健康或酗酒及藥物濫用資訊。如家庭中有多名成人參加了 Medicaid 醫療計畫，則必須由每名申請的成人簽名同意，方能公開資訊。

MEDICAID 管理式護理：如果我將家人新增到 Medicaid 個案且我居住在需要 Medicaid 領用人加入健康計畫的郡，則我瞭解除非此位家人遭到豁免或排除資格，否則他將投保和我家庭相同的健保計畫。

披露教育紀錄：本人授權本地社會服務局和紐約州取得本人子女教育記錄的任何資訊，以便申請相關教育服務的 Medicaid 報銷，並允許聯邦政府機構可於必要時調閱該等資訊。

早期干預計畫：如果我的子女評估紐約州早期干預計畫或我的子女參加紐約州早期干預計畫，我授權本地社會服務部門和紐約州向我的郡早期干預計畫披露我子女的 Medicaid 資格資訊，以供 Medicaid 開立帳單之用。本人同意將該資訊分享給為申請人提供服務的任何學校型健康中心。
PRIVACY NOTICE

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](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/notepriveng.htm](https://www.health.ny.gov/health_care/medicaid/program/hipaa/notepriveng.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:*


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**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.
隱私權通知

此通知說明我們會如何使用及披露與您相關的醫療資訊，並將說明您如何使用此資訊。
請仔細閱讀內容。

紐約 Medicaid 必須向您說明我們會如何使用、分享和保護您的健康資訊。紐約 Medicaid 計畫包含定期的 Medicaid 及 Medicaid Managed Care。計畫是由紐約州衛生署 (New York State Department of Health) 及地方社會服務局 (Local Departments of Social Services) 管理。

您的健康資訊是個人且私密的。
我們會將您的資料視為個人且私密，而且僅會視需要分享您的資料，並會依據此通知的隱私權做法行事。我們必須格外努力以保護接受艾滋 (HIV/AIDS) 或藥物及酒精服務之個人的姓名。

紐約 Medicaid 計畫持有哪些健康資訊？
申請 Medicaid 時，您可能已將您的相關健康資訊提供給我們。當您的醫師、診所、醫院、受管理照護計畫和其他健康照護提供者要求付款請求時，我們也會取得關於您健康、治療及藥物的資訊。

紐約 Medicaid 計畫如何使用及分享您的健康資訊？
我們会在下列情況下分享您的健康資訊:

- 您或您的代表要求我們提供您的健康資訊。
- 政府機關依法 (如稽核) 要求提供資訊。
- 法律要求我們分享您的資訊。

您申請 Medicaid 即表示您授權 Medicaid 計畫使用及分享您的健康資訊，以支付健康照護及營運計畫。例如，我們使用和分享您的資訊以:

- 支付您的醫師、醫院及/或健康照護提供者帳單。
- 確定您獲得優質健康照護，而且確實遵循所有規定及法律。

我們可能會檢閱您的健康資訊:

- 以判定您是否獲得正確的醫療程序或健康照護設備。
- 以針對健康權益的重要變更與您聯絡。
- 以確定您已投保適當的健康計畫。
- 以向其他保險公司收取款項。
- 以判定您是否有資格投保 Medicare 處方保險或可能對您而言更經濟實惠的其他保險計畫。
我們也可能在有限情況下使用和分享您的健康資訊以:

- **研究健康照護**。我們可能查看多名消費者的健康資訊，以找出提供更好的健康照護方法。
- **依據聯邦法律和州法，為您或社區防止出現或響應嚴重的健康或安全問題**。對於其他用途和披露情況，則需要您的書面授權，這些情況包括:
  - 心理治療筆記
  - 出於行銷目的而使用及披露受保護健康資訊，包含與補貼治療相關的溝通
  - 構成出售您受保護的健康資訊的披露行為。

除非依據我方適用之法律的要求，否則我們必須取得您的書面許可，才能出於此通知未提及之目的使用或分享您的健康資訊。

您有哪些權利?

您或您的代表有權:

- 取得此通知的紙本副本。
- 查看或取得您健康資訊的副本。如果您的要求遭拒，則有權審閱拒絕原因。
- 要求變更您的健康資訊。我們會檢視所有要求，但無法變更您醫師、診所、醫院或其他健康照護提供者寄來的帳單。
- 要求限制我們使用和分享您資訊的做法。我們會檢視所有要求，但除非法律要求我們進行此類披露，否則我們不一定會同意您提出的要求。
- 要求我們透過不同方式 (例如，您可以要求我們將郵件寄送到不同地址) 與您聯絡以取得您的健康照護資訊。
- 要求簽署特別表單，以允許我們與您選擇的對象分享您的健康資訊。只要我們尚未與他人分享資訊，您就能隨時撤銷許可。
- 取得已接收您健康資訊的對象清單。此清單不會包含您或您代表要求提供的健康資訊、用於營運紐約 Medicaid 計畫的資訊，或是提供以利實現執法目的的資訊。
- 在任何一項不安全的受保護健康資訊洩露時獲得通知。


*提出申訴並不會遭致處罰。如果我們變更此通知的任何資訊，會將修訂版本張貼於下列網站：


您是否有醫療或心理健康疾病或殘障問題？此問題是否使得您難以瞭解此通知或完成此通知所要求事情？此問題是否使您難以取得 HRA 提供的其他服務？我們可助您一臂之力。致電 212-331-4640 聯絡我們。您也可以前往 HRA 辦公室尋求協助。根據法律，您有權尋求此類協助。