

Continuing Your Medicaid and/or Family Health Plus Benefits

Enclosed is the form required to continue your Medicaid and/or Family Health Plus benefits. If you are a pregnant women, a child under 19, an adult receiving Medicaid without any long term care services or in receipt of Family Health Plus, you no longer need to document your income, new residence or child/adult care expenses when you are renewing your Medicaid/Family Health Plus.

You must send proof of your health insurance premium, if any, and other changes that have occurred in your household in the past year, such as someone started to get other health insurance coverage from an employer. However, in order to determine your eligibility, the amount of income you report will be compared to available computer matches. In some cases the data from the computer match may move you from Medicaid to Family Health Plus. If you want to ensure you receive the correct coverage, you may wish to send proof of your income since the amount you report may not match the amount found in the computer matches. If you decide not to send it now, you may be asked to provide proof of your income and/or resources at a later date. You will be contacted and told what to send in. The enclosed "Documentation Checklist" shows you what you can use as proof of these items.

You may call the social services office for help with this form. There are also community organizations and health plans that can help you. You can call 1-877-934-7587 or 1-800-698-4543 to find a health plan or community organization in your area that provides assistance. If you go to one of these organizations for help, bring this letter with you. You must still return the form and documentation to the address listed on the next page by the date shown. You may wish to keep a copy of this form for your records.

**MAKE SURE YOU ANSWER EVERY QUESTION AND SIGN THE FORM.
RETURN ALL PAGES AND THE DOCUMENTATION BY MAIL OR IN
PERSON TO THE SOCIAL SERVICES OFFICE. YOU DO NOT NEED TO
COME IN FOR AN INTERVIEW.**

CONTINUING YOUR MEDICAID and/or FAMILY HEALTH PLUS BENEFITS

NOTICE DATE:		EFFECTIVE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE				
CASE NUMBER		CIN NUMBER						
CASE NAME (And C/O Name if Present) AND ADDRESS								
<div style="border: 1px solid black; width: 100%; height: 100%; position: relative;"> ┌ ┐ └ ┘ </div>				GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP				
				OR Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____				
				OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

Once a year, you or your representative must renew your eligibility for Medicaid and/or Family Health Plus. You must provide the information that follows and return this form with certain documentation to the following address by

(Date)

FAILURE TO RETURN THIS FORM MAY MEAN YOU WILL LOSE YOUR HEALTH CARE COVERAGE

You may have to send proof of your current income, childcare costs, if any, and other changes that have occurred in your household since last year, such as someone started to get other health insurance coverage from an employer. The enclosed "Documentation Checklist" shows you what you can use as proof of these items. You only need to send proof if the renewal form says you must.

- List all the members of your household that receive Medicaid and/or Family Health Plus. Write each member's name, date of birth and Social Security Number. If you are pregnant or you do not have a Social Security Number because of your immigration status, you may leave the space blank.

	Name	Date of Birth	Sex (M/F)	SSN
01	_____	__/__/__	_____	_____
02	_____	__/__/__	_____	_____
03	_____	__/__/__	_____	_____
04	_____	__/__/__	_____	_____
05	_____	__/__/__	_____	_____
06	_____	__/__/__	_____	_____
07	_____	__/__/__	_____	_____
08	_____	__/__/__	_____	_____
09	_____	__/__/__	_____	_____
10	_____	__/__/__	_____	_____

2 a. Does anyone listed in number 1 have a spouse, parent/step-parent, or child under 21, living in the household who is not receiving Medicaid and/or Family Health Plus?

No.

Yes.

Name of the spouse, parent/step-parent,
or child under 21

Relationship to
Head of Household

b. If yes, does this person want to apply for Medicaid/Family Health Plus?

No.

Yes. **(Provide the information below and send proof of the person's date of birth, and citizenship or immigration status and income, if any. Include this person when you answer the rest of the questions on this form.)**

<u>Last Name</u>	<u>First Name</u>	<u>Date of Birth</u>	<u>Sex (M/F)</u>	<u>Social Security Number</u>
_____	_____	__/__/__	_____	___/___/___
_____	_____	__/__/__	_____	___/___/___

3. Is anyone listed in number 1 or 2 above pregnant?

No.

Yes. Who?

Expected delivery date:

(See instructions on the Documentation Checklist.)

4. Has your address or telephone number changed since you last applied for/renewed your health care coverage?

No.

Yes. My new address and/or telephone number is:

House #	Street	Apt. #
_____	_____	_____
City	State	Zip
_____	_____	_____
Telephone #		

(You must send proof of new address if you are in receipt of long-term care services.)

5. Have your housing expenses changed since you last applied for/renewed your health care coverage?

No

Yes. My new monthly housing payment is: \$ _____

I heat with (gas, oil, electric, etc.) _____

My heat is included in my monthly housing payment. Yes No

6. Has the citizenship or immigration status of anyone renewing changed?

No.

Yes. Who?

(You must send proof from the federal immigration agency showing the person's current citizenship/immigration status.)

7. INCOME:

List the type of income and the amount received by anyone listed in numbers 1 and 2. If you are renewing for Medicaid and are receiving long-term care services (like home care, personal care services, adult day health care, Certified Home Health Agency Services, or Long-Term Home Health Care program) you must send in proof of each income listed. If you are not receiving long-term care services, you do not need to send proof of your income.

DO NOT LEAVE THIS SECTION BLANK

Type of Income (Examples: wages, tips, Social Security Benefits, unemployment benefits, etc.)	Name of Person (Who receives this income?)	Name of Employer, if applicable	How much does the person receive? (before taxes)	How often is the income received? (weekly, every two weeks, monthly, other)

8. EXPENSES

Do you have any of the expenses below? **You must send proof of each expense if you are in receipt of long-term care services.** Everyone must send proof of Health Insurance premium, if any.

Health Insurance Premium	Medicare	Court Ordered Support	Child/ Adult Care Expenses

Are you currently enrolled in the Medicaid Buy-In program for Working People with Disabilities (MBI), or applying for MBI?

- No.
 Yes.

If YES, you must submit proof of your employment. See the enclosed Documentation Checklist for the documents you can use to prove you are employed.

9. RESOURCES

Note: Pregnant woman and children under the age of 19, do not have to provide information about resources, unless the person is participating in the Medicaid spenddown program, or the child is certified blind or disabled. All other recipients must provide the following information.

List all resources owned by the persons listed in numbers 1 and 2. (Resources include money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, or property that someone owns. Do not list your home).

If you do not have any resources please write "NONE" under "Type of Resource"

Type of Resource	Name of Person (Who owns the resource?)	What is the value of the resource?	Bank/Company Name (if applicable)

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If you are renewing for Medicaid and are receiving long-term care services (like home care, personal care services, adult day health care, Certified Home Health Agency Services, or Long-Term Home Health Care program) you must send in proof of each resource listed. If you are not receiving long-term care services, you do not need to send proof of your resources.

The following information is needed to find out about things that may have changed in your household since the last time you applied for/renewed your Medicaid/Family Health Plus. Give us the information **only if it is new or changed**. If the answer is no or the situation does not apply to your household, check "Does Not Apply."

10. NEW OR CHANGED HEALTH INSURANCE: Does Not Apply

a. Since you last applied/renewed, has anyone who had health insurance coverage lost the coverage?

Yes.

Who? Insurance company name: Date Coverage Ended

b. Since you last applied/renewed, has anyone started being covered by health insurance (including Medicare) other than Medicaid/Family Health Plus?

Yes.

Who? Premium amount: \$ Paid How Often:

You must send a copy of the insurance card or a copy of the insurance policy.

c. If you are not insured by your employer now, does the employer offer health insurance?

Yes No

If yes, employer name and telephone number: _____

We may be able to pay the cost of your health insurance premium if it is cost effective.

11. PARENT OR SPOUSE LIVING OUTSIDE THE HOME Does Not Apply

a. Since you last applied/renewed, has the parent or spouse of someone renewing moved out of the home?

Yes.

If yes, are you willing to give us information to help you get health insurance from parent or spouse?

Yes. **Give the following information, if known.**

Name of Parent _____

Name of Spouse: _____

Date of birth _____ Social Security Number _____

Address _____

Parent/Spouse of _____

No

If no, is there any reason (good cause) we should not contact this parent/spouse to help you get health insurance? (An example of good cause is that a family member might be harmed in some way.)

No.

Yes. Explain:

b. Since you last applied/renewed, do you have any new information to help us find a parent or spouse who does not live in the home (e.g., home address or work place)?

No.

Yes. **Give the following information, if known.**

Name of Parent _____

Name of Spouse: _____

Home Address _____

Work Address _____

Parent/Spouse of _____

12. ILLNESS, INJURY OR DISABILITY

Does Not Apply

a. If you are blind or disabled and must pay special expenses (non-medical) in order to work, CHECK HERE
(You must send in receipts for these expenses.)

b. Since you last applied/renewed, has anyone become blind, disabled, or handicapped, or does anyone now have a chronic illness or special health care need?

Yes. Who? _____

Explain: _____

c. Since you last applied/renewed, has anyone had an injury, or disability that was caused by someone else, or that could be covered by insurance other than health insurance (such as homeowner's, auto insurance or worker's compensation)?

Yes. Who? _____

Explain: _____

READ THE TERMS, RIGHTS AND RESPONSIBILITIES SECTION, SIGN AND DATE THIS FORM AND RETURN IT BY THE DATE SHOWN ON PAGE ONE.

By signing this form, I understand that each person listed will be enrolled in the appropriate program, if eligible. I have also read and understand these Terms, Rights and Responsibilities. I certify under penalty of perjury that everything on this renewal form is the truth as best I know.

SIGNATURE of Applicant or Representative

DATE

SIGNATURE of other applying adult

DATE

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this form, I am applying to renew Medicaid and/or Family Health Plus.

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, Family Health Plus 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/Family Health Plus/Child Health Plus 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, Child Health Plus and Family Health Plus programs; 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 Family Health Plus or 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).

OFFICE USE ONLY

Worker Signature	Supervisor Signature	Case Disposition

DOCUMENTATION CHECKLIST

This is a list of documents that the Medical Assistance Programs accept. Please review the enclosed "CONTINUING YOUR MEDICAID, FAMILY HEALTH PLUS BENEFITS" form to determine what documents you need to provide in order to continue your health care coverage.

PROOF OF INCOME (Any recipient may choose to send proof of current income, but Medicaid recipients receiving coverage for long-term care services, such as home care or personal care services, must send proof of current income.)

Earned Income from Employer.....	Current paycheck/stubs (4 consecutive weeks) or letter from employer
Self-Employment Income.....	Current signed income tax return or record of earnings and expenses
Rental/Roomer-Boarder Income.....	Letter from roomer, boarder, tenant or check stub
Unemployment Benefits.....	Award letter/certificate, benefit check stub, correspondence from NYS Dept. of Labor
Private Pensions/Annuities.....	Statement from pension/annuity
Social Security.....	Award letter/certificate, benefit check stub, correspondence from Social Security Administration
Employment Based Sick Pay/Disability Income	Award letter/certificate, benefit check stub, correspondence from source of income
Child Support/Alimony.....	Letter from person providing support, letter from court, child support/alimony check stub
Worker's Compensation.....	Award letter, check stub
Veteran's Benefits.....	Award letter, benefit check stub, correspondence from Veterans Administration
Military Pay.....	Award letter, check stub
Interest/Dividends/Royalties.....	Statement from bank, credit union, or financial institution. Letter from broker. Letter from agent
Support from other Family Members.....	Signed statement or letter from family member
Income from a trust.....	Trust document

PROOF OF EMPLOYMENT (Medicaid recipients currently enrolled in the Medicaid Buy-In program must provide documentation of employment.)

Current paycheck/stub	W-2 form
Detailed written statement from employer	Income tax return

RESIDENCY / HOME ADDRESS (Medicaid recipients receiving coverage for long-term care services must send proof of any change of address.)

ID card with current address	Postmarked, non-window envelope, postcard or magazine label with name, address and date
Driver's license issued within past 6 months	Utility bill within the last six months (gas, electric, cable) or correspondence from a government agency
School Record showing address	Property tax records or mortgage statement
Letter/lease/rent receipt with home address from landlord	

CHILD CARE / DEPENDENT CARE EXPENSES (Medicaid recipients receiving coverage for long-term care services must send proof of this expense, if applicable.)

Written statement from day care center or other child/adult care provider.

HEALTH INSURANCE PREMIUMS (Provide, if applicable.)

Letter from employer	Premium statement	Pay stub
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PRIVATE OR EMPLOYER BASED HEALTH INSURANCE (Provide only if new or changed since you last applied/renewed)

Insurance policy

Premium statement

Insurance Card

Termination letter

PREGNANCY

If someone is now pregnant, a statement from a medical provider including the expected date of delivery is required, unless you have already given a statement to us. If you do not have this statement when you return this renewal form, please get it as soon as possible and send it to your worker.

RESOURCES Medicaid recipients receiving coverage for long-term care services, such as home care or personal care services, must send proof of current resources.

Resources include: money in a bank or credit union, stocks, bonds, mutual funds, certificates of deposit, money market accounts, 401k plans, trust funds, the cash value of life insurance, or property that someone owns. Do not include your home.

Bank statements

Deed or appraisal for Real Estate

Burial agreement

Life Insurance policy

Copies of stocks, bonds, securities

Trust document

SPECIAL WORK EXPENSES FOR BLIND/DISABLED

If you are blind or disabled and must pay special non-medical expenses in order to work, (for example, you need special equipment or transportation) send in receipts that show what the expense is and who provides it.

CITIZENSHIP/IDENTITY

Documents which Establish both Citizenship and Identity

- o U.S. passport;
- o Certificate of Naturalization (N-550 or N-570); or
- o Certificate of U.S. Citizenship (N-560 or N-561).

Secondary Documents which Establish Citizenship but also require one identity document from the Identity

Documentation list below

- o U.S. Birth Certificate showing birth in one of the 50 U.S. States, District of Columbia, American Samoa, Swain's Island, Puerto Rico (if born on or after 1/13/1941), Virgin Islands of the U.S. (on or after 1/17/1917), Northern Mariana Islands (after 11/4/1986 [NMI local time]), or Guam (on or after 4/10/1899);
- o Certification of Report of Birth issued by the Department of State (DS-1350) ;
- o Report of Birth Abroad of a U.S. Citizen (FS-240);
- o Certification of birth issued by Department of State (Forms FS-545 or DS-1350);
- o U.S. Citizen Identification Card (I-197 or I-179);
- o Northern Mariana Identification Card (I-873);
- o American Indian Card with classification code of "KIC" (I-872);
- o Final adoption decree showing U.S. place of birth;
- o Evidence of U.S. civil service employment before 6/1/1976;
- o Military record of service showing U.S. place of birth (i.e., DD-214); or
- o Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000.

Third Level Documents which Establish Citizenship but are less reliable than Secondary Documents (Also requires an identity document)

- o Extract of hospital record on hospital letterhead. The record must have been established at the time of birth and the extract must have been created at least 5 years before the Medicaid application date (or, for children younger than 16, near the time of birth) and must show a U.S. place of birth;
- o Life, health or other insurance record, if it shows a U.S. place of birth and was created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth);
- o Religious record recorded in the U.S. within 3 months of birth showing a U.S. place of birth and either the date of birth or the individual's age at the time the record was made; or
- o Early school record showing date of admission, a U.S. place and date of birth and names and places of birth of the applicant's parents.

Fourth Level Documents which Establish Citizenship but are the least reliable and should only be used in rarest of circumstances (Also requires an identity document)

- Federal or State census record showing U.S. citizenship or a U.S. place of birth; or
- The following other documents are acceptable if they indicate a U.S. place of birth and were created at least 5 years prior to the application date (or, for children younger than 16, near the time of birth):
 - Medical (clinic, doctor, or hospital) record;
 - Seneca Indian tribal census;
 - Bureau of Indian Affairs tribal census records of the Navajo Indians;
 - U.S. State Vital Statistics official notification of birth registration;
 - Delayed U.S. public birth record that is recorded more than 5 years after the person's birth;
 - Statement signed by the physician/midwife who was in attendance at the time of birth; or
 - Bureau of Indian Affairs Roll of Alaska Natives;
- Institutional admission papers from a nursing facility, skilled care facility or other institution (created at least 5 years before the application date) showing a U.S. place of birth; or
- Written affidavit (to be used only in rare instances).

Documents which Establish Identity

- A driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. Canadian driver's licenses may not be used;
- School identification card with a photograph of the individual;
- U.S. military card or draft record;
- Identification card issued by Federal, State, or local government with the same information included on the driver's license;
- Military dependent's identification card;
- Certificate of Degree of Indian Blood, or other U.S. Native American/Alaska native tribal document with photo or other identifying information;
- U.S. Coast Guard Merchant Mariner card;
- A cross-match with a Federal or State governmental, public assistance, law enforcement, or corrections agency's data system;
- If **none** of the above identity documents is available, a combination of three or more corroborating documents such as marriage certificates, divorce decrees, high school or college diplomas, employer ID cards or property deeds/titles. Voter registration cards not acceptable;
- Disabled individuals in residential care facilities may have identity attested to by the facility director or administrator, on behalf of the individual in the facility, when the individual does not have or cannot get any document listed above. This affidavit must be signed under penalty of perjury, but need not be notarized.
- Children under age 16 may have their identity documented using other means:
 - Clinic, doctor or hospital record;
 - School records including report card, day care or nursery school record.
Records must be verified with the issuing school;
 - If no other documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative may be used. An identity affidavit should not be used if a citizenship affidavit was used. Affidavits need not be notarized. Identity affidavits may be used for children under 18 when a school ID card or driver's license is not available to the child until she or he is 18 years of age.

Evidence that Establishes U.S. Citizenship for Collectively Naturalized Individuals

Puerto Rico

- Evidence of birth in Puerto Rico on or after 4/11/1899 and the applicant's or recipient's (A/R's) statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on 1/13/1941; or
- Evidence that the A/R was a Puerto Rican citizen and the A/R's statement that he or she was residing in Puerto Rico on 3/1/1917 and that he or she did not take an oath of allegiance to Spain.

U.S. Virgin Islands

- Evidence of birth in the U.S. Virgin Islands, and the A/R's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/1927; or
- The A/R's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/ 25/1927, and that he or she did not make a declaration to maintain Danish citizenship; or
- Evidence of birth in the U.S. Virgin Islands and the A/R's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on 6/28/1932.

Northern Mariana Islands (NMI)(formerly part of the Trust Territory of the Pacific Islands [TTPI])

- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on 11/3/1986 (NMI local time) and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time); or
- Evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/1981 (NMI local time), voter registration prior to 1/1/1975 and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time); or
- Evidence of continuous domicile in the NMI since before 1/1/1974 and the A/R's statement that he or she did not owe allegiance to a foreign state on 11/4/1986 (NMI local time). If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

Immigrant Status

- The following are the most common United States Citizenship and Immigration Services (USCIS) Forms:
 - I-551 Permanent Resident Card;
 - I-94 Arrival/Departure Record;
 - I-688B or I-766 Employment Authorization Card;
- United States Citizenship and Immigration Services (USCIS) Form I-797-Notice of Action; or
- Evidence of continuous United States Residence prior to 1972.

NOTE: If you are applying only for Medical Assistance, you do not have to tell us about your citizenship or immigration status if you are:

- pregnant; or
- an undocumented immigrant applying for Medical Assistance coverage because of an emergency medical condition. (See Medical Assistance section of Book 2, LOCAL DEPARTMENT OF SOCIAL SERVICES-4148B for more information on citizenship or immigration status).