

ATTACHMENT 21



Department of
Civil Service

PS-451 Statement of Disability - RFP entitled: "Mental Health Substance Use (MHSU) Disorder Program"



Department of
Civil Service

EMPLOYEE BENEFITS DIVISION
NYSHIP Statement of Disability for Dependents

PS-451 (9/2020 L)

If your eligible dependent child is incapable of self-sustaining support because of a mental or physical disability, you may be able to continue coverage for that dependent beyond the age when coverage would usually end.

NYSHIP Disabled Dependent Eligibility Criteria

To continue coverage for a disabled dependent child, the dependent must meet **all** of the criteria below.

1. Dependent Eligibility

The dependent must be eligible for NYSHIP coverage as a dependent. See your *General Information Book* for more information on dependent eligibility. For "other" children who are also disabled, you must provide a completed and verified *NYSHIP Statement of Dependence for "Other" Children (PS-457)* establishing "other" dependent eligibility for NYSHIP along with this form.

2. Disability

The dependent must be incapable of self-sustaining support due to a mental or physical disability that has been verified by a physician.

3. Dependent Age

The dependent's disability must have begun before they would otherwise age out of NYSHIP coverage:

Medical Coverage

The disability must have begun prior to the end of the month of the child's 26th birthday.

Dental and Vision Coverage

The disability must have begun prior to the child's 19th birthday (26th birthday for SEHP Enrollees) or while a full-time student between the ages of 19 and 25.

If the child is incapable of self-sustaining support because of a disability that began while the child was a full-time student after turning age 25, up to four years may be deducted from the dependent student's age for documented service in a branch of the U.S. Military between 19 and 25. If your dental and vision coverage is through a Union Benefit Fund for dental and/or vision, you must contact your Union Benefit Fund directly for information regarding your dependent's eligibility.

4. Marital Status

The dependent must be unmarried.

INSTRUCTIONS FOR COMPLETING THE NYSHIP STATEMENT OF DISABILITY FOR DEPENDENTS FORM PS-451

1. The ENROLLEE completes their portion of the form (the top section of page 2) and provides **pages 2 and 3** to the treating physician.
2. The PHYSICIAN completes their portion of the form (page 3). Once complete, the Enrollee or the physician sends **pages 2 and 3** to the appropriate plan administrator (*The Empire Plan or NYSHIP HMO*).
3. The PLAN ADMINISTRATOR completes their portion (the bottom of page 2) and mails page 2 to the Employee Benefits Division of the Department of Civil Service.

The plan administrator will review the full application and certify or deny the disabling condition of the dependent child. If the condition is certified, the plan administrator will provide the date of the onset of disability and the period of time the disability is certified through to the Employee Benefits Division (EBD) for confirmation of eligibility and/or processing. Your HBA and EBD will not have access to medical documentation.

Once the information has been verified, EBD will notify you directly of the approval or denial of coverage for the disabled dependent child.

Please note that while the plan administrator is reviewing the information, they may reach out to the enrollee or the treating physician for more information.

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Enrollee Portion

Complete this portion of the form and then submit pages 2 and 3 to the treating physician.
 Keep a copy of the completed form for your records.

| Enrollee Information | | | |
|--|------------------------|---|----------|
| Enrollee Last Name | First Name | MI | |
| Health Insurance ID number | Social Security Number | Phone Number | |
| Home Address | City | State | Zip Code |
| Dependent Information | | | |
| Dependent Last Name | First Name | MI | |
| Date of Birth | Social Security Number | Is the dependent married? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Relationship to the Enrollee: <input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Child of Domestic Partner <input type="checkbox"/> 'Other' Child (PS-457 NYSHIP Statement of Dependence is also required) | | | |
| Percentage of support provided by the enrollee: _____% | | Is the dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is the dependent currently enrolled in Medicare Parts A & B? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Personal Privacy Protection Law Notification | | | |
| The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 86 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375. | | | |
| HIPAA Privacy Authorization to Release Protected Health Information | | | |
| By my signature below, I authorize the attending physician to provide my plan administrator or health maintenance organization (HMO) with health information (to be indicated in the Physician Portion of this form) regarding the mental or physical disability of my dependent for whom I am requesting NYSHIP coverage. I also authorize the plan administrator or HMO to disclose its determination (to be indicated in the Plan Administrator Portion of this form) to the Department of Civil Service. The purpose of these disclosures is to determine my dependent's eligibility for NYSHIP coverage and to implement that determination. I understand that I may revoke this authorization in writing at any time, as described in the NYSHIP Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by HIPAA. | | | |
| Enrollee's Signature | | | Date |

Plan Administrator Portion

This portion of the form is to be completed by the appropriate plan administrator (UnitedHealthcare for The Empire Plan or the appropriate NYSHIP Health Maintenance Organization). Once complete, send this page only to: The Department of Civil Service, Employee Benefits Division (EBD), Albany, NY 12239 or by secure fax to 518-485-5590

| | | |
|---|----------------------------------|--|
| Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No | Date the Disability Began: _____ | Disability Certified Through: _____ (Maximum 7 years per certification) |
| Plan Administrator: <input type="checkbox"/> The Empire Plan (UnitedHealthcare) <input type="checkbox"/> NYSHIP HMO - Code _____ Name: _____ | | |
| Authorized Representative | | |
| Signature: _____ | | Date: _____ |

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Physician Portion

All boxes below to be completed by the Treating Physician. Once complete, all pages must be sent to the appropriate plan administrator (Empire Plan or HMO) by the Enrollee or the Treating Physician.

| | | | |
|---|-----------------------------------|---|---|
| Empire Plan or NYS Dental & Vision only Enrollees Mail To: UnitedHealthcare PO Box 1600 Kingston, New York 12402-1600 | | HMO Enrollees Mail To: Mail this form directly to your HMO. | |
| Physician's Name | | Physician's Phone Number | |
| Physician's Address | | City | State Zip Code |
| Patient Name | | Health Insurance ID Number | |
| Is this Dependent incapable of self-sustaining support by reason of physical or mental health disability? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Date dependent became incapable of self-sustaining support: | Estimated duration of disability: | | Date of your most recent examination of this patient: |
| Please provide a complete description of the patient's medical condition, including diagnoses, prognosis, current status, services being received and the specific deficit, impairment or disorder that renders the patient incapable of self-sustaining support. | | | |
| | | | |
| (If more space is necessary, attach additional pages.) PLEASE NOTE: Unless all questions are answered completely, a determination cannot be made. | | | |
| Physician's Signature: _____ | | Date: _____ | |