APPLICANT/RECIPIENT DECLARATION CONCERNING THE LEGALLY RESPONSIBLE RELATIVE'S INCOME/RESOURCES

NYC Human Resources Administration Department of Social Services

MAP-2161 (E) 03/27/2025

DATE: _____

_____ CASE NAME: _____

_____ CASE NUMBER: _____

_____

If you have any questions, call HRA Helpline at 888-692-6116

Dear _____

This form is to be completed by the applicant or recipient who is living with a Legally Responsible Relative (LRR) who has refused to make income and/or resources available for the cost of necessary medical care and services. Legally Responsible Relatives are: spouses (e.g. husband for wife, wife for husband) and parents for children under 21.

The Legally Responsible Relative is not absolved from providing financial resources for the care of his or her spouse or child. The Department of Social Services expects the legally responsible relative to cooperate with the process of substantiating the income and resources of the responsible relative in order to determine the amounts the Legally Responsible Relative will be required to pay**. Legally Responsible Relatives may be taken to court for failure to support their spouses or minor children**. Failure to provide requested financial information may also result in the legally responsible relative being taken to court.

Complete the table below, including your signature and the date, and return this entire form in the enclosed envelope within 10 days

I (Print name) _____ _____ declare that my
(First) (Last)

☐ Spouse ☐ Parent ☐ Other, specify: _____
has refused to make his/her income and/or resources available for the cost of necessary medical care and services. I have read the above and understand that the process of financial review and collection of my Medicaid debt from my legally responsible relative begins when I sign this form.

Name of Legally Responsible Relative: _____ _____
(First) (Last)

Social Security Number of Legally Responsible Relative:_____

In consideration of the determination of my eligibility for Medical Assistance, I hereby assign, to the Commissioner of the New York City Human Resources Administration (Department of Social Services), my right of support from the legally responsible relative named above.

Name of Legally Responsible Relative's Health Care Plan (if applicable)

Type of Health Care Coverage (i.e. Long-Term Care): _____

Policy Number (if applicable): _____

Contact Number: ( )_____
(Area Code)

Signature of Applicant/ Recipient: _____ Date: _____

Worker's Name	Title	Section

Supervisor's Name (Print)	Supervisor's Name (Sign)

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 888-692-6116. 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.