



FAMILY INDEPENDENCE ADMINISTRATION

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POLICY BULLETIN #07-09-EMP

(This Policy Bulletin Replaces PB #06-142-EMP)

WELLNESS, COMPREHENSIVE ASSESSMENT, REHABILITATION AND EMPLOYMENT (WECARE) CLINICAL REVIEW TEAM (CRT)

Date: January 25, 2007	Subtopic(s): CRT
<p> This procedure can now be accessed on the FIAweb.</p>	<p>The purpose of this policy bulletin is to advise all Job Center, Substance Abuse Case Management, and Conciliation and Substance Abuse Service Center staff of the new Wellness, Comprehensive Assessment, Rehabilitation and Employment (WeCARE) Clinical Review Team (CRT) and the codes that will be offered in NYCWAY to refer applicants/participants to CRT for an evaluation. This policy bulletin is informational for all other staff.</p> <p>Individuals who were previously assessed by WeCARE and received a Functional Capacity Outcome (FCO) based on a Biopsychosocial (BPS) assessment may require a subsequent review of the individual's current functional capacity. In order to determine if a new WeCARE medical or specialty assessment is required, a review of the most recent FCO and current medical claim(s) must be evaluated by the CRT. The CRT process will include an interview with the individual and a review of past and current medical documentation.</p> <p>In order to determine if the most recent FCO is clinically appropriate, a clinical review may be required if individuals:</p> <ul style="list-style-type: none"> • were formerly participating in the WeCARE program, are reapplying for public assistance, claiming a medical barrier, and the WeCARE FCO is <u>less than</u> 12 months old; or • are being referred to WeCARE for FCO review due to a Fair Hearing decision.

HAVE QUESTIONS ABOUT THIS PROCEDURE?
Call 718-557-1313 then press 2 at the prompt followed by 765 or
send an e-mail to *FIA Call Center*

The Medical Provider Appointment (**W-538C**) form will be generated when either of these codes is posted.

Individuals will be referred to CRT via the Employability Plan (EP) in NYCWAY. NYCWAY will determine if a WeCARE FCO was posted for the individual within the last 12 months. If one was, the Worker will be prompted to select either Action Code **16HR** (Referral to WeCARE Review Board – Fair Hearing Result) or Action Code **16JR** (Referral to WeCARE Review Board – Previous FCO). The JOS/Worker must select **16JR** in these instances.

If there is no evidence of a former WeCARE FCO or the FCO is more than 12 months old, the Worker will be prompted to post the normal WeCARE referral codes.

Refer to [PD #06-20-OPE](#) for detailed instructions on the Fair Hearing Compliance process.

The **16HR** should be used for Fair Hearing decisions only, and should be posted by the Processing Unit staff responsible for Fair Hearing Compliance. The JOS/Worker in the Processing Unit will be allowed to post the **16HR** outside the EP (an Employment Plan is not required). NYCWAY will determine if the applicant/participant had an FCO within the past 12 months.

- If there is an FCO less than 12 months old, NYCWAY will allow the **16HR** to post. The **W-538C** will be batch mailed to the applicant/participant.
 - If there is no FCO or the FCO is more than 12 months old, NYCWAY will display the error message “Initial Referral Required.” In these instances the JOS/Worker must call in the applicant/participant via the Fair Hearing Compliance Request (**W-186D**) form and schedule an initial WeCARE appointment through the EP per current procedure.
- Whenever the **16HR** posts, the JOS/Worker must send the applicant/participant the Fair Hearing Compliance Statement (**W-186C**), advising him/her of the CRT appointment that was made on his/her behalf.
 - The **W-186C** has been revised to accommodate this process.

W-186C must be sent to the applicant/participant advising them of the medical appointment.

CRT locations

Each vendor has separate CRT locations. The CRT locations are:

Federation of Employment and Guidance Services (FEGS)

Manhattan and Staten Island: 80 Vandam Street, 7th Floor
New York, NY 10013

Bronx: 2432 Grand Concourse, 4th Floor
Bronx, NY 10458

Arbor

Brooklyn: 25 Elm Place, 3rd Floor
Brooklyn, NY 11201

Queens: 42-15 Crescent Street, 8th Floor
Long Island City, NY 11101


Effective Immediately

Related Item:

[PD #06-20-OPE](#)

Attachments:

W-186C Fair Hearing Compliance Statement (Rev. 1/23/07)
W-186C (S) Fair Hearing Compliance Statement (Spanish)
(Rev. 1/23/07)

 Please use Print on Demand to obtain copies of forms.



Date: _____
Case Number: _____
Case Name: _____
Center: _____
FH Number: _____
FH Decision Date: _____

Fair Hearing Compliance Statement

Dear _____ :

Here is how we have complied with the Fair Hearing decision:

Public Assistance

Immediately before your Fair Hearing request, your semimonthly public assistance grant was \$ _____.

We are issuing you \$ _____ as a nonrecurring or retroactive semimonthly public assistance grant for _____
(period covered or special grant type)

This benefit will be available to you after _____ .
(date)

Your restored benefits are being offset against an existing outstanding public assistance claim(s) against you, reducing the benefit balance owed to you. If the claim is satisfied and a balance is still owed, that balance will be issued.

Effective _____, your semimonthly public assistance grant will be \$ _____ .
(date)

You did not lose any public assistance benefits because you received aid-continuing public assistance during the Fair Hearing process. Therefore your public assistance benefits remain the same.

We have reevaluated your eligibility for public assistance and have determined that you are not eligible. You will be sent a separate notice of our determination.

Your public assistance benefits remain unchanged.

Food Stamps

Immediately before your Fair Hearing request, your monthly Food Stamp benefits were \$ _____.

We are issuing you \$ _____ in retroactive food stamps for _____.
(period covered or special grant type)

These food stamps will be available to you after _____.
(date)

You have an outstanding Food Stamp claim of \$ _____ against you.

Your restored benefit has been reduced to offset the claim against you. We are issuing you the balance in the amount of \$ _____, which will be available to you on or after _____. If the claim is satisfied and a balance is still owed, that balance will be issued.
(date)

Effective _____, your monthly Food Stamp benefits will be \$ _____.
(date)

You did not lose any Food Stamp benefits because you received food stamps during the Fair Hearing process. Therefore, your Food Stamp benefits remain the same.

We have reevaluated your eligibility for food stamps and have determined that you are not eligible. You will be sent a separate notice of our determination.

Your Food Stamp benefits remain unchanged.

Medical Assistance

If your Medicaid benefits were interrupted, they will be restored along with your public assistance benefits.

Appointment Scheduled

Based on the decision of your Fair Hearing, we are required to review/reevaluate your medical claim. Therefore, we made an appointment for you with our medical vendor. You will receive a notice in the mail concerning this appointment.

Public Assistance, Food Stamps and/or Medical Assistance

We have been unable to determine if you are eligible for the benefits that were the subject of your Fair Hearing. We mailed you a letter on _____, asking you to come in for an interview and/or to bring the following to the Job Center/Brighton NPA FS Office by _____.
(date) (date)

Because you have failed to respond to our letter, we cannot complete any compliance action until you come in and/or supply the requested information. If you come in and/or bring the information to the Job Center/Brighton NPA FS Office within ten (10) days from the date of this notice, we will consider the information in accordance with the Fair Hearing decision.

Worker's Name Date

Supervisor's Name Date



Fecha: _____
Número del Caso: _____
Nombre del Caso: _____
Centro: _____
Número de FH: _____
Fecha de la
Decisión de FH: _____

Declaración de Cumplimiento de la Audiencia Imparcial

Estimado(a) _____ :

Hemos tomado la(s) siguiente(s) medida(s) en cumplimiento de la decisión de la Audiencia Imparcial:

Asistencia Pública

Inmediatamente antes de su solicitud de Audiencia Imparcial, su concesión quincenal era de \$ _____.

Le hemos asignado una concesión quincenal de asistencia pública de \$ _____ no recurrente o retroactiva para el _____
(período de cobertura o tipo especial de concesión)

Este beneficio estará a su disposición después del _____
(fecha)

Se le ha(n) deducido de sus beneficios restituidos la(s) reclamación(es) de asistencia pública pendiente(s) en contra suya, lo que resulta en la reducción del saldo de beneficios que le corresponde. En caso de que la reclamación se haya cumplido, y que aún se le deba un balance, dicha cantidad se le pagará.

A partir de _____, su concesión quincenal de asistencia pública será de \$ _____
(fecha)

Usted no perdió beneficios de asistencia pública dado que durante el trámite de la Audiencia Imparcial usted recibía asistencia pública continua (aid-continuing). Por lo tanto, sus beneficios de asistencia pública permanecerán sin cambios.

Tras reevaluar su elegibilidad de asistencia pública, hemos determinado que usted no es elegible. Le enviaremos por separado un aviso de dicha determinación.

Su asistencia pública permanecerá sin cambios.

Cupones para Alimentos

Inmediatamente antes de su solicitud de Audiencia Imparcial, su beneficio de Cupones para Alimentos mensual era de \$ _____.

Le hemos otorgado una concesión retroactiva de cupones para alimentos por la cantidad de \$ _____
por _____.
(período de cobertura o tipo especial de concesión)

Esta concesión de cupones para alimentos estará a su disposición después del _____.
(fecha)

Sigue pendiente contra usted una reclamación de Cupones para Alimentos de \$ _____.

Sus beneficios restituidos han sido reducidos para compensar la cantidad que se le reclama. Le hemos otorgado el balance por la cantidad de \$ _____, que estará a su disponibilidad el _____ o
(fecha)

después de esta fecha. Si la cantidad del reclamo es saldada y aún se le debe una diferencia, un pago en esa cantidad será expedido.

A partir del _____, la cantidad de sus beneficios de Cupones para Alimentos será \$ _____.
(fecha)

Usted no perdió beneficios de cupones para alimentos dado que durante el trámite de la Audiencia Imparcial usted recibía cupones para alimentos. Por lo tanto, sus beneficios de Cupones para Alimentos permanecerán sin cambios.

Tras reevaluar su elegibilidad de Cupones para Alimentos y hemos determinado que usted no es elegible. Le enviaremos por separado un aviso de dicha determinación.

Sus beneficios de Cupones para Alimentos permanecerán sin cambios.

Asistencia Médica

Si sus beneficios de Medicaid fueron suspendidos, dichos beneficios serán restituidos junto con sus beneficios de asistencia pública.

Cita Programada

Según la decisión de su Audiencia Imparcial, se nos requiere repasar/reevaluar su reclamo médico. Por lo tanto, le hemos programado una cita con nuestro proveedor médico. Recibirá un aviso por correo acerca de esta cita.

Asistencia Pública, Cupones para Alimentos y/o Asistencia Médica

No hemos podido determinar si usted tiene derecho a los beneficios que fueron disputados en su Audiencia Imparcial. Le enviamos una carta el _____, pidiéndole que se presente a una entrevista y/o
(fecha)

traiga al Centro de Trabajo (Job Center)/Oficina de Cupones para Alimentos no de Asistencia Pública Brighton (Brighton NPA FS Office) los documentos indicados más abajo antes del _____.
(fecha)

Debido a que usted no contestó a nuestra carta, no podemos llevar a cabo ninguna medida de cumplimiento hasta que usted proporcione los datos necesarios. Si usted trae dichos datos al Centro de Trabajo/Oficina de Cupones para Alimentos no de Asistencia Pública Brighton dentro de diez (10) días de la fecha de este aviso, tomaremos los datos en cuenta, conforme a la decisión por parte de la Audiencia Imparcial.

Nombre del Trabajador

Fecha

Nombre del Supervisor

Fecha