# STATE OF NEW YORK
# DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
*Commissioner*

Dennis P. Whalen
*Executive Deputy Commissioner*

**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL**: 02 OMM/ADM-4

**TO:** **Commissioners of Social Services**

**DIVISION**: Office of Medicaid Management

**DATE:** May 28, 2002

**SUBJECT**: Notice and Fair Hearing Procedures for the Long Term Home Health Care Program

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| **SUGGESTED DISTRIBUTION:** | Directors of Social Services<br>Home Care Staff<br>Medicaid Staff<br>Long Term Home Health Care Programs<br>Fair Hearing Staff<br>Legal Staff |
| **CONTACT PERSON**: | Any questions concerning this release should be directed to Dorah Bluth, Bureau of Long Term Care, by calling (518) 474-5271 |
| **ATTACHMENTS:** | Long Term Home Health Care Program Fair Hearing Notices<br>Physician Confirmation Form<br>See Appendix I for a listing of attachments |

**FILING REFERENCES**

| Previous ADMs/INFs | Releases Cancelled | Dept. Regs. | Soc. Serv. Law & Other Legal Ref. | Manual Ref. | Misc. Ref. |
|---|---|---|---|---|---|
| 83 ADM-74 | GIS 01-MA-035 | 18 NYCRR 505.21 | SSL 367-C | | |

## I. PURPOSE

The purpose of this Directive is to advise Local Departments of Social Services (LDSS) and Long Term Home Health Care Programs (LTHHCP) of new fair hearing procedures. These procedures relate to LTHHCP participants' existing as well as new fair hearing rights. With respect to LTHHCP participants' existing fair hearing rights, this Directive includes fair hearing notices that districts must send under the following circumstances described in 83 ADM-74: when the Medicaid recipient's application for participation in the LTHHCP is denied; when the recipient's participation in the LTHHCP is discontinued; and, when there is a change in the recipient's level of care budget cap from Skilled Nursing Facility (SNF) to Health Related Facility (HRF). With respect to LTHHCP participants' new fair hearing rights, this Directive describes the additional fair hearing rights now required when a LDSS or a LTHHCP proposes to deny, discontinue or reduce one or more services in the recipient's plan of care, **contrary to treating physician's orders,** but does not propose to terminate the recipient's participation in the LTHHCP.

## II. BACKGROUND

Under 83-ADM-74, LTHHCP applicants/recipients were entitled to notice and fair hearing rights under the three circumstances described above. The Department's previous ADMS required districts to develop their own notices. To assure uniformity, the Department has now developed standard notices that districts must send when they or the LTHHCP propose to deny a Medicaid recipient's application to participate in the LTHHCP, to discontinue the recipient's participation in the LTHHCP or to reduce the level of care budget from SNF to HRF.

In addition, this Directive implements new fair hearing rights consistent with stipulations in the Simmons v. DeBuono (Supreme Court, Erie County, 2000) and Bernard v. Novello (E.D.N.Y.,2001)cases. Under these new procedures, LTHHCP recipients are entitled to notice and fair hearing rights when a LDSS or a LTHHCP proposes to deny, reduce or discontinue one or more services in the LTHHCP participant's plan of care contrary to his or her treating physician's orders, but does not propose to terminate the recipient's participation in the LTHHCP. In GIS 01-MA-035, the Department previously provided fair hearing notices for the specific services involved in the Simmons and Bernard litigation (personal care, home health aide, and physical therapy). A recipient may also request a fair hearing when other services in the LTHHCP plan of care are denied, discontinued or reduced contrary to the treating physician's orders (e.g., occupational therapy). To simplify the notices, the Department has developed a general notice which must be used whenever a service in the recipient's LTHHCP plan of care is denied, discontinued or reduced contrary to the recipient's treating physician's orders. Districts should use these notices and discontinue use of the notices set forth in GIS 01-MA-035.

## III. PROGRAM IMPLICATIONS

Previous fair hearing requirements outlined in 83 ADM-74 required LTHHCP applicants/recipients to be provided timely notice and fair

hearing rights when the LDSS or the LTHHCP:

- denies the application for participation in the LTHHCP;
- discontinue the recipient's participation in the LTHHCP; or
- changes the budgeting level of care for a current LTHHCP participant from SNF to HRF.

These rights will not be affected by the addition of the rights outlined in this Directive.

The additional rights are:

- LTHHCP recipients are entitled to fair hearing rights when the number of hours of Medicaid funded services previously authorized under their care plans is reduced or discontinued **contrary to their treating physicians' orders**.
- LTHHCP recipients are entitled to fair hearing rights when Medicaid funded services are denied **contrary to their treating physicians' orders**.
- LTHHCP recipients are entitled to fair hearing rights under 18 NYCRR section 358-3.1(b)(6) to review the adequacy of their Medicaid funded services.

## IV. REQUIRED ACTION

### A. NOTIFICATION REQUIREMENTS FOR LTHHCP & LDSS

#### 1) Notices for Existing Fair Hearing Rights

Prior to issuance of this Directive, the Department had not provided fair hearing notices to be used when the LDSS or the LTHHCP denied an application for participation in the LTHHCP, discontinued a recipient's participation in the LTHHCP or when the budgeting level of care changed from SNF to HRF. To assure statewide uniformity, all fair hearing notices for LTHHCP applicants/recipients have been prepared and are appended to this Directive as attachments.

All the notices included as attachments to this Directive have two versions. Attachments followed by an **A** contain the fair hearing phone numbers for all districts other than New York City. Attachments followed by a **B** contain fair hearing phone numbers for New York City only. Each LDSS must use the appropriate notice for that particular district.

**Attachment I,** "Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the Long Term Home Health Care Program", is to be used to notify an LTHHCP applicant/recipient that a decision has been made to authorize, reauthorize or deny his or her application to participate in the LTHHCP.

**Attachment II,** "Notice of Intent to Discontinue Your Participation in the Long Term Home Health Care Program (LTHHCP)", is to be used when participation in the LTHHCP is discontinued.

**Attachment III,** "Notice of Intent to Reduce Your SNF Level Budget To An HRF Budget In The Long Term Home Health Care Program," is to be used when the budgeting level used to determine the budget cap for a recipient changes from Skilled Nursing Facility (SNF) to Health Related Facility (HRF).

**2) New Procedures and Fair Hearing Notice for Reductions or Discontinuances of Services within the LTHHCP**

When the LDSS (or LTHHCP) intends to reduce or discontinue one or more services being provided to a LTHHCP recipient, but does not propose to discontinue the recipient's participation in the LTHHCP itself, the following action must be taken before the LTHHCP may implement the proposed reduction or discontinuance of the service:

a) The LDSS must consult with the recipient's physician, as set forth in (b), below, to determine whether the physician agrees with the proposed reduction or discontinuance of the service. Alternatively, the LDSS may request that the LTHHCP consult with the recipient's physician, as set forth in (b), below. Regardless of whether the LDSS or the LTHHCP assumes responsibility for consulting with the physician, the LDSS and the LTHHCP must communicate closely with each other regarding the recipient's case and the proposed reduction or discontinuance. Close communication and coordination is vital to assure that both the LDSS and the LTHHCP are cognizant of whether the physician agrees, or disagrees, with the proposed reduction or discontinuance since the physician's decision governs whether the LDSS must send the recipient the timely and adequate notice of the proposed action with the right to request a fair hearing with aid-continuing that is appended to this directive as Attachment V, described in (2)(d), below.

b) The LDSS must obtain a written statement from the recipient's physician that indicates whether the physician agrees or disagrees with the proposed change in the recipient's care plan. The Department has developed the Physician Confirmation Form for this purpose. The Physician Confirmation Form is appended to this directive as **Attachment IV**. The LDSS must use this form, which is to be printed on legal-size paper, or request the Department's approval to use a different form. The LDSS may, alternatively, request that the LTHHCP obtain the written statement from the recipient's physician. When the LTHHCP agrees to obtain this written statement, the LDSS must advise the LTHHCP that the LTHHCP must also use the Physician Confirmation Form or request the Department's approval to use a different form. The LDSS (or the LTHHCP) must send the Physician Confirmation Form (or a Department approved equivalent) to the recipient's physician

and request that the physician complete and return the form within 10 business days. The Physician Confirmation Form contains a space for the LDSS (or the LTHHCP) to indicate the person to whom the physician should return the form, together with such person's telephone and fax numbers. It is preferable that the physician be requested to return the Physician Confirmation Form directly to the LDSS; however, should the form be returned to the LTHHCP, the LTHHCP must notify the LDSS immediately of the physician's determination whether he or she agrees or disagrees with the proposed reduction or discontinuance. The physician's decision governs whether the LDSS must send the recipient the fair hearing notice appended to this directive as Attachment V.

c) When the physician agrees with the proposed reduction or discontinuance of the recipient's service, the LDSS must notify the LTHHCP that the LTHHCP may implement the proposed reduction or discontinuance. The LDSS is not required to send the recipient a timely and adequate notice with fair hearing and aid-continuing rights. However, the LTHHCP should advise the recipient, in accordance with existing procedures and requirements established pursuant to 10 NYCRR Part 763, of the change in the recipient's service.

d) When the physician disagrees with the proposed reduction or discontinuance, or fails to return the Physician Confirmation Form, the LDSS must send the recipient the fair hearing notice that is appended to this directive as **Attachment V**, and which is entitled "Notice of Intent to Reduce or Discontinue Services in the Long Term Home Health Care Program (LTHHCP) Contrary To Physician's Orders." The LDSS must use this notice when it proposes to reduce or discontinue services in the LTHHCP contrary to the recipient's treating physician's order but the recipient's participation in the LTHHCP will not be terminated. The LDSS must also send the LTHHCP a copy of the fair hearing notice. The LDSS must also advise the LTHHCP that it may not reduce or discontinue the service before the effective date of the notice and, if the recipient requests a fair hearing with aid-continuing prior to the effective date of the notice, the LDSS must also advise the LTHHCP that it may not reduce or discontinue the service pending issuance of the fair hearing decision.

**Attachment V, "**Notice of Intent to Reduce or Discontinue Services in the Long Term Home Health Care Program (LTHHCP) Contrary To Physician's Orders," is to be used when services will be discontinued or reduced in the LTHHCP contrary to the treating physician's orders, but the recipient's participation in the LTHHCP will not be terminated.

e) The LDSS must notify the LTHHCP immediately if aid continuing is granted for discontinued or reduced services, and instruct the LTHHCP to continue services unchanged pending the fair hearing determination.

**3) Notices for Denials**

When the LDSS or LTHHCP intends to deny a service contrary to physician's orders, the LDSS is required to send the appropriate notice, below, with fair hearing rights to the recipient. The LDSS must send a copy of the notice to the LTHHCP so it has a copy for its records.

**Attachment VI,** "Notice of Intent To Deny Services In The Long Term Home Health Care Program Contrary To Physician's Orders," is to be used when services will be denied in the LTHHCP contrary to the treating physician's orders, but the recipient's participation in the LTHHCP will not be terminated

**B. REQUIREMENTS FOR FAIR HEARING NOTICES**

When completing fair hearing notices, LDSS must include a brief description of the action the district intends to take and the specific reason for such action.

The notices provided with this Directive are mandated and must be reproduced by the LDSS until such time as the notices are printed and become available from the Department. The notices must be on legal size paper and must be reproduced as two sided notices rather than two-paged notices. Any modification to these notices must be submitted in accordance with procedures described in 97 ADM-13, "Procedure for Requesting Approval of Local Equivalent Forms".

**IMPORTANT:** The notices provided as part of this Directive are in two versions: attachments followed by an **A** have the fair hearing phone numbers used by districts other than New York City; attachments followed by a **B** have the fair hearing phone numbers for New York City. The LDSS must use the appropriate notice for that particular district.

## V. SYSTEMS IMPLICATIONS

None

## VI. EFFECTIVE DATE

Immediately

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management

# APPENDIX I

| | |
|---|---|
| Attachment 1A | Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the Long Term Home Health Care Program (LTHHCP) |
| Attachment 1B | Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the Long Term Home Health Care Program (LTHHCP) (NYC Only) |
| Attachment IIA | Notice of Intent to Discontinue Your Participation in the Long Term Home Health Care Program (LTHHCP) |
| Attachment IIB | Notice of Intent to Discontinue Your Participation in the Long Term Home Health Care Program (LTHHCP) (NYC Only) |
| Attachment IIIA | Notice of Intent to Reduce Your SNF Level Budget to an HRF Budget in the Long Term Home Health Care Program (LTHHCP) |
| Attachment IIIB | Notice of Intent to Reduce your SNF Level Budget to an HRF Budget in the Long Term Home Health Care Program (LTHHCP) (NYC Only) |
| Attachment IV | Physician Confirmation Form |
| Attachment VA | Notice of Intent to Reduce or Discontinue Services in the Long Term Home Health Care Program (LTHHCP) Contrary to Physician's Orders |
| Attachment VB | Notice of Intent to Reduce or Discontinue Services in the Long Term Home Health Care Program (LTHHCP) Contrary to Physician's Orders (NYC Only) |
| Attachment VIA | Notice of Intent to Deny Services in the Long Term Home Health Care Program (LTHHCP) Contrary to Physician's Orders |
| Attachment VIB | Notice of Intent to Deny Services in the Long Term Home Health Care Program (LTHHCP) Contrary to Physician's Orders (NYC Only) |

**ATTACHMENT I A**

# NOTICE OF INTENT TO AUTHORIZE/REAUTHORIZE OR DENY YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

| NOTICE DATE: | | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**A DETERMINATION HAS BEEN MADE REGARDING YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM.**

❑ **YOUR PARTICIPATION IN THE LTHHCP HAS BEEN <u>AUTHORIZED</u> FOR THE PERIOD: _____ TO _____. YOUR CARE NEEDS WILL BE REASSESSED EVERY 120 DAYS.**

❑ **YOUR PARTICIPATION IN THE LTHHCP HAS BEEN <u>REAUTHORIZED</u> FOR THE PERIOD: _____ TO _____. YOUR CARE NEEDS WILL BE REASSESSED EVERY 120 DAYS.**

❑ **YOUR APPLICATION FOR THE LONG TERM HOME HEALTH CARE PROGRAM IS <u>DENIED</u> BECAUSE**:

_____

_____

_____

_____

_____

_____

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO AUTHORIZE/REAUTHORIZE OR DENY YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing.

**RIGHT TO A FAIR HEARING**: If you believe the above action is wrong you may request a State fair hearing. You may request a fair hearing by:

**(1) Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

**If you live in:** Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

**If you live in:** Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

**If you live in:** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

**If you live in:** Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

**If you live in:** Nassau or Suffolk County: (516) 739-4868

**OR**

(2) **Writing:** By sending a copy of this notice **completed**, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

_____

_____

Name_____ Case Number: _____

Address: _____County: _____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

ATTACHMENT I B

# NOTICE OF INTENT TO AUTHORIZE/REAUTHORIZE OR DENY YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) *NYC-ONLY*

| NOTICE DATE: | | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**A DETERMINATION HAS BEEN MADE REGARDING YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM.**

❑ **YOUR PARTICIPATION IN THE LTHHCP HAS BEEN <u>AUTHORIZED</u> FOR THE PERIOD: _____ TO _____. YOUR CARE NEEDS WILL BE REASSESSED EVERY 120 DAYS.**

❑ **YOUR PARTICIPATION IN THE LTHHCP HAS BEEN <u>REAUTHORIZED</u> FOR THE PERIOD: _____ TO _____. YOUR CARE NEEDS WILL BE REASSESSED EVERY 120 DAYS.**

❑ **YOUR APPLICATION FOR THE LONG TERM HOME HEALTH CARE PROGRAM IS <u>DENIED</u> BECAUSE**:

_____

_____

_____

_____

_____

_____

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO AUTHORIZE/REAUTHORIZE OR DENY YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) *NYC ONLY*

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing.

## STATE FAIR HEARING

**RIGHT TO A FAIR HEARING:** If you believe the above action is wrong you may request a State fair hearing.

**HOW TO ASK FOR A FAIR HEARING: You** can ask for a fair hearing in **writing, by phone, by fax or in person.**

***Writing****:* Send a copy of this notice to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. (Please keep a copy for yourself).

***Phoning****:* (212) 417-6550 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

***Fax:*** Sending a copy of this notice to (518) 473-6735

***Walk-in:*** Bring a copy of this notice to New York State Office of Temporary and Disability Assistance at 14 Boerum Place, 1st Fl., Brooklyn, New York or 330 W. 34th Street, 3rd Fl., NY, NY.

☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**LEGAL ASSISTANCE: If** you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the **front** of this notice or write to us at the address on the **front** of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. Usually they will be provided to you within three working days of when you ask for them. If your hearing is within three working days of when you ask for the documents, they will be given to you at the hearing.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.

ATTACHMENT II A

# NOTICE OF INTENT TO DISCONTINUE YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**THIS IS TO INFORM YOU THAT WE INTEND TO DISCONTINUE YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM EFFECTIVE _____**

**BECAUSE:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO DISCONTINUE YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continued unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe the above action is wrong you may request a State fair hearing. You may request a State fair hearing by::

**(1) Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

**If you live in:** Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

**If you live in:** Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

**If you live in:** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

**If you live in:** Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

**If you live in:** Nassau or Suffolk County: (516) 739-4868

**OR**

(2) **Writing:** By sending a copy of this notice **completed**, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

_____

_____

Name_____ Case Number: _____

Address: _____County: _____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR BENEFITS:** If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

ATTACHMENT II B

# NOTICE OF INTENT TO DISCONTINUE YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) NYC ONLY

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**THIS IS TO INFORM YOU THAT WE INTEND TO DISCONTINUE YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM EFFECTIVE _____ BECAUSE:**

_____

_____

_____

_____

_____

_____

_____

_____

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO DISCONTINUE YOUR PARTICIPATION IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) NYC ONLY

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continued unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

## STATE FAIR HEARING

**RIGHT TO A FAIR HEARING:** If you believe the above action is wrong you may request a State fair hearing.

**HOW TO ASK FOR A FAIR HEARING: You** can ask for a fair hearing in **writing, by phone, by fax or in person.**

***Writing:*** Send a copy of this notice to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. (Please keep a copy for yourself).

***Phoning:*** (212) 417-6550 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

***Fax:*** Sending a copy of this notice to (518) 473-6735

***Walk-in:*** Bring a copy of this notice to New York State Office of Temporary and Disability Assistance at 14 Boerum Place, 1st Fl., Brooklyn, New York or 330 W. 34th Street, 3rd Fl., NY, NY.

☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR BENEFITS**: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE: If** you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the **front** of this notice or write to us at the address on the **front** of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. Usually they will be provided to you within three working days of when you ask for them. If your hearing is within three working days of when you ask for the documents, they will be given to you at the hearing.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.

ATTACHMENT III A

# NOTICE OF INTENT TO REDUCE YOUR SNF LEVEL BUDGET TO AN HRF BUDGET IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**THIS IS TO INFORM YOU THAT WE INTEND TO REDUCE YOUR BUDGET CAP IN THE LONG TERM HOME HEALTH CARE PROGRAM FROM A SKILLED NURSING FACILITY (SNF) LEVEL TO A HEALTH RELATED FACILITY (HRF) LEVEL.**

**THIS MEANS YOUR MONTHLY BUDGET CAP IS BEING CHANGED FROM $_____ TO $_____ WHICH IS _____% OF THE COST OF NURSING HOME CARE IN YOUR DISTRICT.**

**THE COST OF THE SERVICES YOU RECEIVE IN THE LTHHCP CANNOT EXCEED THE BUDGET CAP.**

**WE INTEND TO TAKE THIS ACTION BECAUSE:**

_____

_____

_____

_____

_____

_____

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO REDUCE YOUR SNF LEVEL BUDGET TO AN HRF BUDGET IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continued unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe the above action is wrong you may request a State fair hearing. You may request a State fair hearing by:

**(1) Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

**If you live in:** Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

**If you live in:** Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

**If you live in:** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

**If you live in:** Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

**If you live in:** Nassau or Suffolk County: (516) 739-4868

**OR**

(2) **Writing:** By sending a copy of this notice **completed**, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

_____

_____

Name_____ Case Number: _____

Address: _____County: _____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR BENEFITS:** If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

# NOTICE OF INTENT TO REDUCE YOUR SNF LEVEL BUDGET TO AN HRF BUDGET IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) NYC ONLY

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**THIS IS TO INFORM YOU THAT WE INTEND TO REDUCE YOUR BUDGET CAP IN THE LONG TERM HOME HEALTH CARE PROGRAM FROM A SKILLED NURSING FACILITY (SNF) LEVEL TO A HEALTH RELATED FACILITY (HRF) LEVEL.**

**THIS MEANS YOUR MONTHLY BUDGET CAP IS BEING CHANGED FROM $_____ TO $_____ WHICH IS _____% OF THE COST OF NURSING HOME CARE IN YOUR DISTRICT.**

**THE COST OF THE SERVICES YOU RECEIVE IN THE LTHHCP CANNOT EXCEED THE BUDGET CAP.**

**WE INTEND TO TAKE THIS ACTION BECAUSE:**

_____

_____

_____

_____

_____

_____

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO REDUCE YOUR SNF LEVEL BUDGET TO AN HRF LEVEL IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) NYC ONLY

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continued unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

## STATE FAIR HEARING

**RIGHT TO A FAIR HEARING:** If you believe the above action is wrong you may request a State fair hearing.

**HOW TO ASK FOR A FAIR HEARING: You** can ask for a fair hearing in **writing, by phone, by fax or in person.**

***Writing:*** Send a copy of this notice to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. (Please keep a copy for yourself).

***Phoning:*** (212) 417-6550 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

***Fax:*** Sending a copy of this notice to (518) 473-6735

***Walk-in:*** Bring a copy of this notice to New York State Office of Temporary and Disability Assistance at 14 Boerum Place, 1st Fl., Brooklyn, New York or 330 W. 34th Street, 3rd Fl., NY, NY.

☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR BENEFITS**: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE: If** you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the **front** of this notice or write to us at the address on the **front** of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. Usually they will be provided to you within three working days of when you ask for them. If your hearing is within three working days of when you ask for the documents, they will be given to you at the hearing.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.

# PHYSICIAN CONFIRMATION FORM

For Reductions or Discontinuances of Services Within the LTHHCP

**Patient's Name** _____ **Date**_____

**Date of Birth** _____**Physician's Name** _____

**CIN#** _____**Physician's Fax Number** _____

A Medicaid recipient may request a State fair hearing when a social services district or a long term home health care program (LTHHCP) proposes to reduce or discontinue a service the Medicaid recipient receives within the LTHHCP and the recipient's treating physician disagrees with the proposed reduction or discontinuance of the service.

We are proposing to reduce or discontinue one or more services your patient receives within the LTHHCP. We must know whether you agree with this proposed change. (We are NOT proposing to discontinue your patient's participation in the LTHHCP itself.)

We are proposing that _____
(insert name of service)
be changed as follows:

**FROM:**_____

_____

_____

**TO**: _____

_____

_____

**BECAUSE**: _____

_____

_____

**PLEASE INDICATE WHETHER YOU AGREE WITH THIS PROPOSED CHANGE.**

☐ I **AGREE** with this proposed change.

☐ I **DISAGREE** with this proposed change BECAUSE (optional)

_____

_____

_____

**PLEASE RETURN THIS FORM WITHIN 10 BUSINESS DAYS TO:**

_____

_____

_____

TELEPHONE NO:_____

FAX NO:_____

_____ _____

**Physician's Signature** **Date**

ATTACHMENT V A

# NOTICE OF INTENT TO REDUCE OR DISCONTINUE SERVICES IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) CONTRARY TO PHYSICIAN'S ORDERS

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**THIS IS TO INFORM YOU THAT WE INTEND TO TAKE THE FOLLOWING ACTION ON YOUR _____ IN THE LTHHCP.**

❑ **REDUCE**

Although your physician may disagree with us, your _____ will be reduced effective _____

(LIST HOURS AND FREQUENCY, IF APPROPRIATE)

**From:** _____

_____

_____

(LIST HOURS AND FREQUENCY, IF APPROPRIATE

**To:** _____

_____

_____

We intend to take this action because:

_____

_____

_____

_____

❑ **DISCONTINUE**

Although your physician may disagree with us, your _____ will be discontinued effective _____ because:

_____

_____

_____

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO REDUCE OR DISCONTINUE SERVICES IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) CONTRARY TO THE PHYSICIAN'S ORDERS

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continued unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe the above action is wrong you may request a State fair hearing. You may request a State fair hearing by:

**(1) Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

**If you live in:** Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

**If you live in:** Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

**If you live in:** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

**If you live in:** Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

**If you live in:** Nassau or Suffolk County: (516) 739-4868

**OR**

(2) **Writing:** By sending a copy of this notice **completed**, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

_____

_____

Name_____ Case Number: _____

Address: _____County: _____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR BENEFITS:** If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

# NOTICE OF INTENT TO REDUCE/DISCONTINUE SERVICES IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) CONTRARY TO PHYSICIAN'S ORDERS NYC ONLY

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**THIS IS TO INFORM YOU THAT WE INTEND TO TAKE THE FOLLOWING ACTION ON YOUR _____ IN THE LTHHCP.**

❑ **REDUCE**

Although your physician may disagree with us, your _____ will be reduced effective _____

(List hours and frequency, if appropriate)
**From:** _____

(List hours and frequency, if appropriate)
**To:** _____

We intend to take this action because:

❑ **DISCONTINUE**

Although your physician may disagree with us, your _____ will be discontinued effective _____because:

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO REDUCE/DISCONTINUE SERVICES IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) CONTRARY TO PHYSICIAN'S ORDERS NYC ONLY

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continued unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

## STATE FAIR HEARING

**RIGHT TO A FAIR HEARING:** If you believe the above action is wrong you may request a State fair hearing.

**HOW TO ASK FOR A FAIR HEARING: You** can ask for a fair hearing in **writing, by phone, by fax or in person.**

***Writing****:* Send a copy of this notice to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. (Please keep a copy for yourself).

***Phoning****:* (212) 417-6550 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL.)

***Fax:*** Sending a copy of this notice to (518) 473-6735

***Walk-in:*** Bring a copy of this notice to New York State Office of Temporary and Disability Assistance at 14 Boerum Place, 1st Fl., Brooklyn, New York or 330 W. 34th Street, 3rd Fl., NY, NY.

☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR BENEFITS**: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE: If** you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file that we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file that you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access phone number on the **front** of this notice or write to us at the address on the **front** of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. Usually they will be provided to you within three working days of when you ask for them. If your hearing is within three working days of when you ask for the documents, they will be given to you at the hearing.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the phone numbers on the **front** of this notice or write to us at the address on the **front** of this notice.

# NOTICE OF INTENT TO DENY SERVICES IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) CONTRARY TO PHYSICIAN'S ORDERS

| NOTICE DATE: | | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (And C/O Name if Present) AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>OR Agency Conference _____<br>Fair Hearing information and assistance _____<br>Record Access _____<br>Legal Assistance information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

**THIS IS TO INFORM YOU THAT WE INTEND TO DENY YOUR REQUEST FOR THE FOLLOWING SERVICES IN THE LTHHCP:**_____

_____.

**Your physician wants you to receive the following services (list hours and frequency):**

_____

_____

_____

_____

**Even though your physician wants you to receive these services, we are denying these services because:**

_____

_____

_____

_____

The law and/or regulation which allows us to do this is 18 NYCRR 505.21.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

# NOTICE OF INTENT TO DENY SERVICES IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP)CONTRARY TO PHYSICIAN'S ODERS

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing.

**RIGHT TO A FAIR HEARING**: If you believe the above action is wrong you may request a State fair hearing. You may request a fair hearing by:

**(1) Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

**If you live in:** Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

**If you live in:** Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 266-4868

**If you live in:** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

**If you live in:** Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

**If you live in:** Nassau or Suffolk County: (516) 739-4868

**OR**

(2) **Writing:** By sending a copy of this notice **completed**, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

_____

_____

Name_____ Case Number: _____

Address: _____County: _____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

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# NOTICE OF INTENT TO DENY SERVICES IN THE LONG TERM HOME HEALTH CARE PROGRAM (LTHHCP) CONTRARY TO PHYSICIAN'S ORDERS NYC ONLY

| NOTICE DATE: | | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
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_____

**Your physician wants you to receive the following services (list hours and frequency):**

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☐ I want a fair hearing. I do not agree with the agency's action. (You may explain why you disagree below, but you do not have to include a written explanation.)

_____

_____

_____

Signature of Client: _____ Date: _____

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