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: 04 OMM/ADM-1

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: January 15, 2004

SUBJECT: Notice and Fair Hearing Procedures For the Care At Home Medicaid Waiver Program

SUGGESTED DISTRIBUTION:
Directors of Social Services
Medicaid Staff
Care At Home Coordinators
Home Care Staff
Legal Staff
Fair Hearing Staff
Staff Development Coordinators

CONTACT PERSON:
Any questions concerning this release should be directed To Colleen Maloney, Bureau of Maternal & Child Health, by calling (518) 486-6562, or e-mail at cam09@health.state.ny.us

ATTACHMENTS:
Attachment IA, Notice of Decision to Approve or Deny Enrollment in the Care At Home Waiver Program
Attachment IB, Notice of Decision to Approve or Deny Enrollment in the Care At Home Waiver Program (NYC ONLY)
Attachment IIA, Notice of Decision to Discontinue Participation in the Care At Home Waiver Program
Attachment IIB, Notice of Decision to Discontinue Participation in the Care At Home Waiver Program (NYC ONLY)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR 505.21	SSL 366.6		

I. Purpose

The purpose of this Directive is to advise Local Departments of Social Services (LDSS) of new fair hearing procedures. These procedures relate to Medicaid Care At Home (CAH) I or II waiver participants' and applicants' existing and new fair hearing rights. This Directive includes fair hearing notices that districts must send under the following circumstances:

1. When the application for enrollment in the CAH waiver is denied.

2. When the application for enrollment in CAH waiver is approved.

3. When the CAH enrollee's participation in the CAH waiver program is discontinued.

II. Background

All CAH applicants/recipients are entitled, under certain circumstances, to fair hearing notice and rights. Administrative Directive 86 ADM-4 entitled, "Federal Waivers for Home and Community Based Services: Implementation of Chapter 906 of the Laws of 1984," instructed districts to give adequate and timely fair hearing notice when approving or denying a waiver application or terminating benefits under the waiver. Districts were required to develop their own notices. To assure uniformity, the Department has now developed standard notices that districts must send when they approve or deny an application to participate in the CAH waiver, or to discontinue the recipient's participation in the CAH waiver.

III. Program Implementation

Fair hearing requirements set forth in 86 ADM-4 required districts to provide CAH applicants/recipients with timely and adequate fair hearing rights when benefits under the waiver were denied or terminated. CAH applicants and recipients are entitled to fair hearing rights under 18 NYCRR §358-3.1(b)(6). These requirements have not changed. However, the LDSS must now use the attached mandated forms to notice CAH recipients and applicants regarding their fair hearing rights:

- CAH I and II applicants when their application to the waiver is denied.

- CAH I and II applicants when their application to the waiver is approved.

- CAH I and II recipients when their enrollment in the waiver is discontinued.

Fair hearing requirements for CAH recipients who have requested home adaptations or vehicle modifications are contained in 00 OMM/ADM-4.

IV. Required Action

A. Notification Requirements for the CAH Program and LDSS

Prior to issuance of this Directive, the Department did not provide State mandated fair hearing notices to be used when the LDSS denied or approved an application for participation in the Medicaid CAH waiver program, or when the CAH enrollment for the recipient was terminated. To assure statewide uniformity, all fair hearing notices for the CAH applicant/recipient have been prepared and are appended to this Directive as attachments.

Attachment I, A and B, "Notice of Decision to Approve or Deny Enrollment in the Care At Home I or II Waiver Program," is to be used to notify a CAH applicant that a decision has been made to either authorize or deny his or her application to participate in the CAH I or II waiver program.

Attachment II, A and B, "Notice of Decision to Discontinue Participation in the Care At Home I or II Wavier Program," is to be used when a recipient's participation in the CAH waiver program is being discontinued.

B. New Procedures and Fair Hearing Notices for CAH I and II

1. Application Acceptance or Denials

When a determination has been reached on a CAH I or II application either to deny or approve the application for enrollment, the LDSS CAH coordinator or designee will complete and send the Notice of Decision (Attachment 1), "To Authorize or Deny Participation in the CAH I or II Waiver Program." The determination issued may be:

- Once the applicant's application is reviewed by the LDSS CAH staff and determined that he or she does not meet the minimum eligibility qualifications, or

- Once the application has been reviewed by the State Department of Health (SDOH) and the LDSS has been notified in writing by the SDOH that the application is accepted or denied for enrollment.

Once the appropriate action has been determined, the LDSS CAH Coordinator or designee will fill in the information at the top of the notice and indicate under "Check One" the appropriate decision, and if the application is approved, the effective date. Additional written information may be added by the District.

2. Discontinued Cases

When a determination has been reached to discontinue a recipient's participation in the CAH I or II wavier program, the LDSS CAH coordinator or designee will complete and send the Notice of Decision (NOD) (Attachment II, A & B) "To Discontinue Participation in the CAH I or II Waiver Program." This determination may be due to:

- The recipient turning 18 years of age and aging out of the waiver.
- The recipient moving out of the county or state.
- The recipient no longer meeting the eligibility requirements for the CAH waiver.
- The recipient being transferred from the CAH wavier into another waiver program, or even a transfer between CAHI and CAH I.
- The family (on behalf of the recipient) refusing to cooperate with the periodic eligibility requirements.

Once the appropriate reason for disenrollment has been determined, the LDSS CAH Coordinator or designee will fill in the information at the top of the page and indicate under the effective date of termination from the CAH waiver. Additional written information may be added by the District.

C. Requirements for Fair Hearing Notices

The notices provided with this Directive are mandated and must be reproduced by the LDSS without modification 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 back-to-back. Any LDSS proposed modification to these notices must be submitted for approval in accordance with procedures described in 97 ADM-13, "Procedure for Requesting Approval of Local Equivalent Form."

V. System Implications

1. When an application for CAH I or II is approved and the NOD is sent, the LDSS staff must enter the appropriate Recipient Restriction/Exemption (R/E) code, either 62 for CAH I or 63 for CAH II to the WMS file. The enrollment date on the NOD will be the begin date for the R/E code.

2. When the CAH I or II enrollee is being disenrolled from the waiver and the NOD is sent, the staff will remove the appropriate R/E code, either 62 for CAH I or 63 for CAH II from the WMS file. The termination date on the NOD will be the end date for the R/E code.

VI. Effective Date

Immediately.

_____
Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management

Attachments

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management

ATTACHMENT IA

NOTICE OF DECISION TO APPROVE OR DENY ENROLLMENT IN THE CARE AT HOME I AND II WAIVER PROGRAM

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

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

CHECK ONE

☐ Your application for enrollment in the NYS DOH Medicaid Care at Home Waiver I or II (circle one) Program has been **APPROVED** effective_____. Your case needs will be reassessed every 120 days.

☐ Your application for enrollment in the NYS DOH Medicaid Care at Home I or II (circle one) Waiver Program has been **DENIED** for the reasons stated below.

We intend to take this action because:

_____

_____

_____

_____

_____

_____

_____

This decision was made pursuant to Section 366(6) of the New York State Social Services Law.

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.
READ THE BACK OF THIS NOTICE FOR DETAILS ON HOW TO APPEAL.

cc: _____, Case Management Agency

RIGHT TO A CONFERENCE (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call us at _____, or write to us at _____, to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you ask for a fair hearing. This is not the way to request a fair hearing. If you ask for a conference, you are still entitled to a fair hearing.

STATE FAIR HEARING INFORMATION

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

HOW TO REQUEST A FAIR HEARING

You can ask for a fair hearing **in writing, by phone, by fax or in person.**

TELEPHONING: (Please have this notice with you when you call.)

If you live in: Cattaraugus, Chautauqua, Eire, 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: (845) 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 WRITE: Send a complete copy of this notice completed (all three pages) to the Office of Administrative Hearings, New York State Office of Temporary Disability and Assistance (NYS OTDA), P. O. Box 1930, Albany, NY 12201. Please keep a copy for yourself.

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

Walk-In: _____-

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

_____

_____

Waiver Applicant's Name: _____ Address: _____

Date: _____

SIGNATURE OF CLIENT/PARENT/GUARDIAN_____

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

HEARING INFORMATION

WHAT TO EXPECT AT A FAIR HEARING: The State will send you a notice, which tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think the decision is wrong. You can bring a lawyer, a relative, a friend, or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why the decision is wrong and a chance to give the hearing officer written papers which explain why the decision is wrong.

To help you explain at the hearing why you think the decision is wrong, you should bring any witnesses who can help you. You should also bring any papers you have that you think may help you.

At the hearing, you and your lawyer or other representatives can ask questions of witnesses which may help 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.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. They will provide you with free copies of the documents from your file, which will be given 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.

If you want copies of documents from your file, you should ask for them ahead of time by calling us at the number on the front of this notice or by writing us at the address on the front of this notice. Usually they will be sent 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, please 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.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management

ATTACHMENT IB

NOTICE OF DECISION TO APPROVE OR DENY ENROLLMENT IN THE CARE AT HOME I AND II WAIVER PROGRAM
(NYC-ONLY)

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

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

CHECK ONE:

☐ Your application for enrollment in the NYS DOH Medicaid Care at Home Waiver I or II (circle one) Program has been **APPROVED** effective_____. Your care needs will be reassessed every 120 days.

☐ Your application for enrollment in the NYS DOH Medicaid Care at Home I or II (circle one) Waiver Program has been **DENIED** for the reasons stated below.

We intend to take this action because:

_____

_____

_____

_____

_____

_____

_____

This decision was made pursuant to Section 366(6) of the New York State Social Services Law.

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.
READ THE BACK OF THIS NOTICE FOR DETAILS ON HOW TO APPEAL.

cc: _____, Case Management Agency

Right to A Conference (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call us at _____, or write to us at _____, to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you ask for a fair hearing. This is not the way to request a fair hearing. If you ask for a conference, you are still entitled to a fair hearing.

STATE FAIR HEARING INFORMATION

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

HOW TO REQUEST A FAIR HEARING

You can ask for a fair hearing **in writing, by phone, by fax or in person.**

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

OR WRITE: Send a complete copy of this notice (all three pages) to the Office of Administrative Hearings, New York State Office of Temporary Disability and Assistance (NYS OTDA), P. O. Box 1930, Albany, NY 12201. Please keep a copy for yourself.

Fax: Sending a copy of this notice all three pages) 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 West 34th Street, 3rd Fl., New York, New York.

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

_____

_____

Waiver Applicant's
Name: _____ Address: _____

Date: _____

SIGNATURE OF CLIENT/PARENT/GUARDIAN_____

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

HEARING INFORMATION

WHAT TO EXPECT AT A FAIR HEARING: The State will send you a notice, which tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think the decision is wrong. You can bring a lawyer, a relative, a friend, or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why the decision is wrong and a chance to give the hearing officer written papers which explain why the decision is wrong.

To help you explain at the hearing why you think the decision is wrong, you should bring any witnesses who can help you. You should also bring any papers you have that you think may help you.

At the hearing, you and your lawyer or other representatives can ask questions of witnesses which may help 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.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: TO HELP YOU GET READY FOR THE HEARING, YOU HAVE A RIGHT TO LOOK AT YOUR FILE. THEY WILL PROVIDE YOU WITH FREE COPIES OF THE DOCUMENTS FROM YOUR FILE, WHICH WILL BE GIVEN 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.

If you want copies of documents from your file, you should ask for them ahead of time by calling us at the number on the front of this notice or by writing us at the address on the front of this notice. Usually they will be sent to you within three working days of when you asked for them. If your hearing is within five working days of when you ask for them, your documents may be given to you within three working days of the request or 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, PLEASE 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.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management

ATTACHMENT IIA

NOTICE OF DECISION TO DISCONTINUE PARTICIPATION IN THE CARE AT HOME I AND II WAIVER PROGRAM

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

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

☐ Your enrollment in the NYS DOH Medicaid Care at Home I or II (circle one) Waiver Program will be **DISCONTINUED** effective _____ for the reasons stated below.

We intend to take this action because:

_____

_____

_____

_____

_____

_____

_____

This decision was made pursuant to Section 366(6) of the New York State Social Services Law.

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.
READ THE BACK OF THIS NOTICE FOR DETAILS ON HOW TO APPEAL.

cc: _____, Case Management Agency

Right to A Conference (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call us at _____, or write to us at _____, to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you ask for a fair hearing. If you ask for a conference, you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. Read below for fair hearing information.

STATE FAIR HEARING INFORMATION

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

HOW TO REQUEST A FAIR HEARING

You can ask for a fair hearing **in writing, by phone, by fax or in person.**

TELEPHONING: (Please have this notice with you when you call.)

If you live in: Cattaraugus, Chautauqua, Eire, 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: (845) 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 WRITE: Send a complete copy of this notice (all three pages) to the Office of Administrative Hearings, New York State Office of Temporary Disability and Assistance (NYS OTDA), P. O. Box 1930, Albany, NY 12201. Please keep a copy for yourself.

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

Walk-In: _____

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

_____

_____

Waiver Applicant's Name: _____ Address: _____

Date: _____

SIGNATURE OF CLIENT/PARENT/GUARDIAN_____

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

HEARING INFORMATION

WHAT TO EXPECT AT A FAIR HEARING: The State will send you a notice, which tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think the decision is wrong. You can bring a lawyer, a relative, a friend, or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why the decision is wrong and a chance to give the hearing officer written papers which explain why the decision is wrong.

To help you explain at the hearing why you think the decision is wrong, you should bring any witnesses who can help you. You should also bring any papers you have that you think may help you.

At the hearing, you and your lawyer or other representatives can ask questions of witnesses which may help 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 Medial 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.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. They will provide you with free copies of the documents from your file, which will be given 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.

If you want copies of documents from your file, you should ask for them ahead of time by calling us at the number on the front of this notice or by writing us at the address on the front of this notice. Usually they will be sent to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you 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, please 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.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management

ATTACHMENT IIB

NOTICE OF DECISION TO DISCONTINUE PARTICIPATION IN THE CARE AT HOME I AND II WAIVER PROGRAM
(NYC-ONLY)

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

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

☐ Your enrollment in the NYS DOH Medicaid Care at Home I or II (circle one) Waiver Program will be **DISCONTINUED** effective _____ for the reasons stated below.

We intend to take this action because:

_____

_____

_____

_____

_____

_____

_____

This decision was made pursuant to Section 366(6) of the New York State Social Services Law.

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

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READ THE BACK OF THIS NOTICE FOR DETAILS ON HOW TO APPEAL.

cc: _____, Case Management Agency

Right to A Conference (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call us at _____, or write to us at _____, to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you ask for a fair hearing. If you ask for a conference, you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. Read below for fair hearing information.

STATE FAIR HEARING INFORMATION

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

HOW TO REQUEST A FAIR HEARING

You can ask for a fair hearing **in writing, by phone, by fax or in person.**

CALL: **(212) 417-6550** (Please have this notice with you when you call.)

OR WRITE: Send a complete copy of this notice (all three pages) to the Office of Administrative Hearings, New York State Office of Temporary Disability and Assistance (NYS OTDA), P. O. Box 1930, Albany, NY 12201. Please keep a copy for yourself.

Fax: Sending a copy of this notice (all three pages) 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 West 34th Street, 3rd Fl., New York, New York.

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

_____

_____

Waiver Applicant's
Name: _____ Address: _____

Date: _____

SIGNATURE OF CLIENT/PARENT/GUARDIAN_____

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

HEARING INFORMATION

WHAT TO EXPECT AT A FAIR HEARING: The State will send you a notice, which tells you when and where the fair hearing will be held.

At the hearing, you will have a chance to explain why you think the decision is wrong. You can bring a lawyer, a relative, a friend, or someone else to help you do this. If you cannot come yourself, you can send someone to represent you. If you are sending someone who is not a lawyer to the hearing instead of you, you must give this person a letter to show the hearing officer that you want this person to represent you at the hearing.

At the hearing, you and your lawyer or other representative will have a chance to explain why the decision is wrong and a chance to give the hearing officer written papers which explain why the decision is wrong.

To help you explain at the hearing why you think the decision is wrong, you should bring any witnesses who can help you. You should also bring any papers you have that you think may help you.

At the hearing, you and your lawyer or other representatives can ask questions of witnesses which may help 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 Medial 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.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. They will provide you with free copies of the documents from your file, which will be given 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.

If you want copies of documents from your file, you should ask for them ahead of time by calling us at the number on the front of this notice or by writing us at the address on the front of this notice. Usually they will be sent to you within three working days of when you asked for them. If your hearing is within five working days of when you ask for them, your documents may be given to you within three working days of the request or 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, please 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.