STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Jamew W. Clyne, Jr.
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 09 OLTC/ADM-1

TO: Commissioners of Social Services

DIVISION: Office of Long Term Care

DATE: October 9, 2009

SUBJECT: Notice and Fair Hearing Procedures for the AIDS Home Care Program

SUGGESTED DISTRIBUTION:

Directors of Social Services
Home Care Services Staff
Medicaid Staff
AIDS Home Care Program providers
Legal Staff
Fair Hearing Staff

CONTACT PERSON:

Any questions concerning this release should be directed to Doreen Sharp, Bureau of Medicaid Long Term Care Waivers, by calling 518-474-5271

ATTACHMENTS:

See Appendix I for a listing of attachments
AIDS Home Care Program Fair Hearing Notices
Physician Confirmation Form

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
92 ADM-25 02 OMM/ADM-4		18 NYCRR §505.21 18 NYCRR Part 358 10 NYCRR §763.5	SSL 367-e		"Health and Safety Standards for Certified Home Health Agencies", Health Facilities Series, 93-3 January 29, 1993

I. Purpose

The purpose of this directive is to advise social services districts and providers of AIDS home care programs of revised notices for use in the AIDS home care program. This directive also clarifies that the notice and fair hearing procedures set forth in 02 OMM/ADM-4, entitled 'Notice and Fair Hearing Procedures for the Long Term Home Health Care Program," also generally apply to AIDS home care programs.

II. Background

An AIDS home care program is a coordinated plan of care and services provided at home to persons who are medically eligible for placement in a hospital or nursing facility and who: (a) are diagnosed by a physician as having acquired immune deficiency syndrome; or (b) are deemed by a physician, within the physician's judgment, to be infected with the etiologic agent of acquired immune deficiency syndrome, and who have an illness, infirmity or disability which can be reasonably ascertained to be associated with such infection.

AIDS home care programs may be provided only by providers of long term home health care programs that the commissioner of health has authorized to provide AIDS home care programs.

In 1992, the former New York State Department of Social Services issued an administrative directive, 92 ADM-25, entitled "AIDS Home Care Program (Chapter 622 of the Laws of 1988)." Attached to this directive was a notice for use in the AIDS home care program.

In 2002, the Department issued an administrative directive, 02 OMM/ADM-4, entitled "Notice and Fair Hearing Procedures for the Long Term Home Health Care Program." Attached to this directive were several notices for use in the long term home health care program.

III. Program Implications

Social services districts must cease use of the notice appended to 92 ADM-25. Districts must use the notices appended to this directive when notifying Medicaid recipients of action taken with respect to their participation in AIDS home care programs.

In addition, social services districts and AIDS home care program providers must follow the procedures set forth in this directive with respect to Medicaid recipients who are applicants for, or recipients of, AIDS home care program services. These notice and fair hearing procedures are based on the notice and fair hearing procedures set forth in 02 OMM/ADM-4, which applied to Medicaid recipients' notice and fair hearing rights within the long term home health care program. Social services districts should continue to follow 02 OMM/ADM-4 for guidance on notice and fair hearing rights of Medicaid recipients who are applicants for, or recipients of, long term home health care program services other than AIDS home care program services.

IV. Required Action

Social services districts must use the notices appended to this directive when taking action with respect to a Medicaid recipient's participation in an AIDS home care program.

A. Authorization, reauthorization or denial of participation in the AIDS home care program

When a social services district authorizes or reauthorizes a Medicaid recipient for the AIDS home care program or denies a Medicaid recipient participation in the AIDS home care program, it must send the Medicaid recipient the notice appended to this directive as Attachment I," Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the AIDS Home Care Program (AHCP)." The district worker must check the appropriate box on the notice, whether authorization, reauthorization or denial. When the district is authorizing or reauthorizing the recipient for the AIDS home care program, the worker must insert the beginning and ending dates of the authorization or reauthorization period. When the district denies participation in the AIDS home care program, the notice must include the specific reason for the denial.

Providers of AIDS home care programs and district staff must have a reasonable, sympathetic attitude toward recipients and be sensitive to the fact that, because of the recipients' age, medical problems or mental condition, some recipients may exhibit behavior that, although not physically dangerous, may be irritating to staff. Staff should be able to handle a reasonable degree of difficult behavior that may be exhibited by some recipients, provided that such behavior does not jeopardize the ability of staff to care for the recipient safely and adequately at home or jeopardize the safety of staff. Irritating behavior is not a sufficient basis for refusal to admit a Medicaid recipient or to propose to discontinue the recipient's AIDS home care program services.

B. Discontinuation of participation in the AIDS home care program

Providers of AIDS home care program services are reminded of Department regulations at 10 NYCRR § 763.5(h) relating to the discharge of patients, including the circumstances under which discharge may be appropriate, and the necessity for a discharge plan. Providers are also reminded that, during the course of care, they are expected to identify in the plan of care, patient behaviors that interfere with care but that do not imminently threaten staff safety. Efforts should be made in collaboration with other case managers or protective services for adults to work with the patient and family in changing patient or family behavior. Such efforts could include, but are not limited to, provision of counseling and behavior modification services by social work staff; psychiatric consultation and therapy, if indicated; further medical condition consultation and evaluation to determine if there is a treatable medical basis for the difficult behavior; and training of staff in behavior management. Reasonable efforts to assess and work with other entities to implement behavior management strategies that address patient care problems as identified on the plan of care should be attempted before the patient's participation in the AIDS home care program services are

proposed to be discontinued. Further information may be found in Department of Health Memorandum, HHA-1, "Health and Safety Standards for Certified Home Health Agency Patients," Health Facilities Series 93-3, January 29, 1993.

When, despite these efforts, discharge of a Medicaid recipient from the AIDS home care program is appropriate, the discharge must be implemented consistent with the recipient's notice, fair hearing and aid-continuing rights, as explained below.

The social services district must send the recipient the notice appended to this directive as Attachment II, "Notice of Intent to Discontinue Your Participation in the AIDS Home Care Program (AHCP)." The notice must include the specific reason or reasons why the district proposes to discontinue the recipient's participation in the program.

The notice must also specify the effective date of the proposed discontinuance of the recipient's participation in the AIDS home care program. The effective date listed on the notice must be at least 10 days later than the notice date. The district must send the provider of AIDS home care program services a copy of this notice and advise the provider that it may not discontinue the recipient's participation in the program before the effective date of the notice.

When the recipient requests a fair hearing with aid-continuing before the effective date of the notice, the recipient is entitled to receive AIDS home care program services unchanged pending the issuance of the fair hearing decision. The social services district must notify the AIDS home care program provider immediately if the Office of Administrative Hearings of the NYS Office of Temporary and Disability Assistance issues an aid-continuing directive. The district must take all steps necessary to implement the aid-continuing directive, whether by directing the provider to continue providing services unchanged until the fair hearing decision is issued or to continue providing services unchanged until another AIDS home care program provider has assessed the recipient and is willing to admit the recipient and provide services unchanged until the fair hearing decision is issued.

C. Reduction or discontinuance of one or more AIDS home care program services

The following provisions apply only when the social services district or AIDS home care program provider proposes to reduce or discontinue one or more services that the Medicaid recipient receives in the AIDS home care program but the recipient will continue to be an AIDS home care program participant. When the district or provider propose to discontinue the Medicaid recipient's participation in the AIDS home care program altogether, the procedures set forth at Section IV.B. of this directive, entitled "Discontinuance of participation in the AIDS home care program," must be followed.

When the social services district or AIDS home care program provider intends to reduce or discontinue one or more services being provided to an AIDS home care program participant, but does not propose to discontinue the recipient's participation in the AIDS home care program itself, the following action must be taken before the AIDS

home care program provider may implement the proposed reduction or discontinuance.

1. The social services district must consult with the recipient's physician to determine whether the physician agrees with the proposed reduction or discontinuance of the service. Alternatively, the district may request that the AIDS home care program provider consult with the recipient's physician. Regardless of whether the district or the provider assumes responsibility for consulting with the physician, both entities must communicate closely regarding the recipient's case and the proposed reduction or discontinuance. Close communication and coordination is vital to assure that the district and the provider know whether the physician agrees or disagrees with the proposed reduction or discontinuance since the physician's decision governs whether the district must send the recipient the timely and adequate notice of the proposed action with the right to request a fair hearing with aid-continuing

2. The social services district 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. Alternatively, the district may request that the AIDS home care program provider obtain the written statement from the recipient's physician. The Physician Confirmation Form must be used for this purpose. This form is appended to this directive as Attachment III. The district or provider must use this form or request the Department's approval to use a different form. The district or provider, if the provider agrees, must send the Physician Confirmation Form to the recipient's physician and request that the physician complete and return the form within ten business days. The form contains a space for the district or provider to indicate the person to whom the physician should return the form, together with that person's telephone and fax numbers. It is preferable that the physician be requested to return the form directly to the district; however, should the form be returned to the provider, the provider must notify the district immediately of the physician's determination whether he or she agrees with the proposed reduction or discontinuance. The physician's decision governs whether the district must send the recipient a notice with the right to request aid-continuing.

3. When the physician agrees with the proposed reduction or discontinuance of the recipient's services within the AIDS home care program, the district must notify the provider that the provider may implement the proposed reduction or discontinuance. The district is not required to send the recipient a timely and adequate notice with fair hearing and aid-continuing rights when the recipient's physician agrees with the proposed action. However, the provider should advise the recipient of the change in the recipient's plan of care, as required by Department regulations at 10 NYCRR § 763.2(a)(5).

4. When the physician disagrees with the proposed reduction or discontinuance, or fails to return the Physician Confirmation Form, the district must send the recipient the notice appended to this directive as Attachment IV. This notice is entitled "Notice of Intent to Reduce or Discontinue Services in the AIDS Home Care

Program (AHCP) Contrary to Physician's Orders." This notice must be used when one or more AIDS home care program services will be discontinued or reduced contrary to the treating physician's orders but the recipient's participation in the AIDS home care program will continue.

The notice must list the specific service or services that are proposed to be reduced or discontinued. The notice must also include the specific reason or reasons for the proposed reduction or discontinuance of the AIDS home care program service or services and the effective date of the proposed reduction or discontinuance. The effective date listed on the notice must be at least 10 days later than the notice date. The district must send the provider of AIDS home care program services a copy of this notice and advise the provider that it may not reduce or discontinue the service or services before the effective date of the notice.

5. When the recipient requests a fair hearing with aid-continuing before the effective date of the notice, the recipient is entitled to receive AIDS home care program services unchanged pending the issuance of the fair hearing decision. The social services district must notify the AIDS home care program provider immediately if the Office of Administrative Hearings of the NYS Office of Temporary and Disability Assistance issues an aid-continuing directive. The district must take all steps necessary to implement the aid-continuing directive, whether by directing the provider to continue providing services unchanged until the fair hearing decision is issued or to continue providing services unchanged until another AIDS home care program provider has assessed the recipient and is willing to admit the recipient and provide services unchanged until the fair hearing decision is issued.

D. Denial of an AIDS home care program service

When the social services district or AIDS home care program provider denies one or more services that the recipient's physician has ordered, the district must send the recipient the notice that is appended to this directive as Attachment V, "Notice of Intent to Deny Services in the AIDS Home Care Program (AHCP) Contrary to Physician's Orders." The district must also send a copy of the notice to the provider.

This notice is used only when one or more services ordered by the recipient's physician are denied but the recipient's participation in the AIDS home care program will continue. If the district or provider deny the recipient participation in the AIDS home care program altogether, the procedures set forth at Section IV.A. of this directive, entitled "Authorization, reauthorization or denial of participation in the AIDS home care program," must be followed.

The notices provided with this Directive are mandated and must be downloaded for use from the intranet Library of Official Documents at http://health.state.nyenet/revlibrary2.htm or from CentraPort by selecting "Medicaid" from functional areas and then by going to "ADMs".

V. Systems Implications

None

VI. Effective Date

Immediately

Mark Kissinger, Deputy Commissioner
Office of Long Term Care

LISTING OF ATTACHMENTS

Attachment I	DOH-4324A - Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the AIDS Home Care Program (AHCP)
Attachment II	DOH-4322A - Notice of Intent to Discontinue Your Participation in the AIDS Home Care Program (AHCP)
Attachment III	DOH-4337A – Physician Confirmation Form
Attachment IV	DOH-4338A - Notice of Intent to Reduce or Discontinue Services in the AIDS Home Care Program (AHCP) Contrary to Physicians Orders
Attachment V	DOH-4340A - Notice of Intent to Deny Services in the AIDS Home Care Program (AHCP) Contrary to Physicians Orders

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Long Term Care

ATTACHMENT I

NOTICE OF INTENT TO AUTHORIZE/REAUTHORIZE OR DENY YOUR PARTICIPATION IN THE AIDS HOME CARE PROGRAM (AHCP)

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 _____ 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.

A DETERMINATION HAS BEEN MADE REGARDING YOUR PARTICIPATION IN THE AIDS HOME CARE PROGRAM.

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

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

❑ **YOUR APPLICATION FOR THE AHCP 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

(Reverse)

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 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.

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

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**
3) **On-Line:** Complete and send the online request form at: **http://www.otda.state.ny.us/oah/forms.asp. OR**
4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, 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:_____

_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

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 first page 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 page 1 of this notice or write us at the address printed at the top of page 1 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 page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

NOTICE OF INTENT TO DISCONTINUE YOUR PARTICIPATION IN THE AIDS HOME CARE PROGRAM (AHCP)

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 _____ **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.

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

The law and/or regulation(s) which allow us to do this are 18 NYCCR 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

(Reverse)

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 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.

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

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**
3) **On-Line:** Complete and send the online request form at: **http://www.otda.state.ny.us/oah/forms.asp. OR**
4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, 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:_____

_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

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 first page 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 page 1 of this notice or write us at the address printed at the top of page 1 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 page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

PHYSICIAN CONFIRMATION FORM

For Reductions or Discontinuances of Services
Within the AIDS Home Care Program (AHCP)

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 AIDS Home Health Care Program (AHCP) proposes to reduce or discontinue a service the Medicaid recipient receives within the AHCP 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 AHCP. We must know whether you agree with this proposed change. (We are NOT proposing to discontinue your patient's participation in the AHCP itself.)

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

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

NOTICE OF INTENT TO REDUCE OR DISCONTINUE SERVICES IN THE AIDS HOME CARE PROGRAM (AHCP) 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 _____ 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.

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

☐ **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(s) which allow us to do this are 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

(Reverse)

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 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.

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

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**
3) **On-Line:** Complete and send the online request form at: **http://www.otda.state.ny.us/oah/forms.asp. OR**
4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, 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:_____

_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

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 first page 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 page 1 of this notice or write us at the address printed at the top of page 1 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 page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

NOTICE OF INTENT TO DENY SERVICES IN THE AIDS HOME CARE PROGRAM (AHCP) 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 _____ 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.

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

_____.

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(s) which allow us to do this are 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

(Reverse)

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 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.

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

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**
3) **On-Line:** Complete and send the online request form at: **http://www.otda.state.ny.us/oah/forms.asp. OR**
4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, 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:_____

_____

_

_____

_

_____

_

_

Print Name: _____ Case Number_____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

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