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-7

TO: **Commissioners of Social Services**

DIVISION: Office of Medicaid Management

DATE: December 10, 2002

SUBJECT: Family Planning Benefit Program

SUGGESTED DISTRIBUTION:

Medicaid Directors
Staff Development Coordinators
Temporary Assistance Directors
CAP Coordinators
TOP Coordinators

CONTACT PERSON:

Local District Liaison
Upstate: (518) 474-8216
NYC: (212) 268-6855

ATTACHMENTS:

Attachment I Family Planning Benefit Program Application
Attachment II Declaration of Age
Attachment III Memorandum of Understanding
Attachment IV Notice of Decision on Medical Assistance Application (Family Planning Acceptance)
Attachment V Notice of Decision on Your Family Planning Application (Acceptance)
Attachment VI Notice of Decision on Medical Assistance Application: Medicaid/Family Health Plus Denial/FPBP Declination

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
			Chapter 57 of Laws of 2000 SSA 1903(a)(5) SSL 366 (1)(a)(11)		Dear Commissioner Letter 9/28/98

I. PURPOSE

The purpose of this Office of Medicaid Management Administrative Directive (OMM/ADM) is to inform local social services districts of the Family Planning Benefit Program demonstration program approved as a waiver pursuant to Section 1115 of the Social Security Act by the Centers for Medicaid and Medicare Services (CMS). This directive advises local social services districts (LDSS) of:

- the eligibility requirements;
- the application process; and
- the systems enhancements for the Family Planning Benefit Program (FPBP).

II. BACKGROUND

Governor Pataki and the New York State Legislature enacted the Family Planning Benefit Program as part of Chapter 57 of the Laws of 2000. Chapter 57 added Section 366(1)(a)(11) of the Social Services Law to expand eligibility for family planning services to individuals with incomes at or below 200% of the Federal Poverty Level (FPL), contingent upon approval of a federal waiver. The waiver was approved by CMS on September 27, 2002. It is effective October 1, 2002.

The purpose of the FPBP is to offer Medicaid coverage for family planning services on a fee-for-service basis to men and women with incomes at or below 200% of the FPL. FPBP services will be available only to persons who are not otherwise eligible for Medicaid or Family Health Plus, or who have indicated in writing that they want to apply for the FPBP only.

The FPBP is intended to increase access to family planning services designed to enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unintended pregnancies. In addition, the program is intended to improve health outcomes and reduce the cost and societal burdens associated with unintended pregnancies.

The expansion will provide only Medicaid reimbursed family planning services, exclusive of abortions, for eligible individuals. Federal financial participation for such services will be available at a rate of 90 percent in accordance with Section 1903(a)(5) of the Social Security Act. There is no local cost for services provided under the FPBP.

The FPBP does not replace the Family Planning Extension Program (FPEP) that is now available to a limited population of women. In September 1998, under the 1115 Partnership Plan waiver, the FPEP was implemented to provide 24 months of family planning services for women who lost Medicaid eligibility but were pregnant while in receipt of Medicaid. Women who qualify may receive a full range of family planning services, exclusive of abortions, from one of the participating providers (Title X Clinics) for 26 months after the end of their pregnancy regardless of changes in income. If a woman does not recertify for Medicaid after the 60 day postpartum extension, she is still eligible for FPEP for 24 months; there is no application for FPEP. In addition, there are no citizenship requirements for FPEP.

III. Program Implications

As a result of legislation and waiver approval by the federal government, the FPBP will be implemented effective October 1, 2002. Family planning benefits will be available to individuals of child bearing age whose income is at or below 200% of the FPL.

A. Scope of Program Benefits

Eligible recipients will have access to family planning services from all Medicaid enrolled family planning providers including hospital based and free standing clinics, county health department clinics, federally qualified health centers or rural health centers, obstetricians and gynecologists, family practice physicians, licensed midwives, nurse practitioners, and family planning related services from pharmacies and laboratories. The scope of the family planning benefits is the same as those currently available to all fully eligible Medicaid recipients. These services include: all FDA approved birth control methods, devices and supplies and related testing and procedures; comprehensive reproductive health history and physical examination, screening for sexually transmitted diseases, and HIV and cervical cancer (when performed within the context of a family planning visit); clinical breast exam; male testicular exam performed during a family planning visit; emergency contraceptive services and follow-up; screening and related diagnostic testing for conditions impacting contraceptive choice, i.e. glycosuria, proteinuria, hypertension, etc.; laboratory tests to determine eligibility for contraceptive choice; male and female sterilization; preconception counseling, pregnancy testing and non-directive counseling; and client education and counseling services required to render the above services effective. Abortion is not covered in the FPBP.

As is described in Section V. Systems Implications, a new Coverage Code (18) supports provision of family planning services only to eligible individuals.

B. Eligibility Requirements

Males and females of child bearing age whose income is at or below 200% of the FPL, may be eligible for the FPBP when they:

- are New York State residents; and
- are citizens or otherwise eligible aliens with satisfactory immigration status; and are either:

- not otherwise eligible for Medicaid or Family Health Plus (FHPlus); or
- have indicated in writing that they want to apply for the FPBP only; or
- are under age 21 and living with their parents and apply for family planning services and do not have parental financial information; eligibility will be determined by comparing their own income to 200% of FPL.

There is no resource test for the FPBP.

When individuals described above are denied or terminated from Medicaid and/or FHPlus, eligibility must be determined for the FPBP. However, the individual may choose not to participate in family planning coverage, either at the interview or by contacting the district to request that FPBP coverage be terminated after receiving the acceptance notice. (See Section IV.A.)

The FPBP does not require previous eligibility for Medicaid during pregnancy.

Persons may choose to apply for the FPBP only, without applying for Medicaid and FHPlus. This includes teens living with their parents, and anyone else who wants family planning services only. They must use the new one-page application, "Application: Family Planning Benefit Program", (Attachment I). Persons using this application must sign the "Declination of Medicaid and Family Health Plus Eligibility Determinations" statement, and thus cannot be found eligible for those programs through the FPBP application. Anyone who signs this declination may apply for Medicaid and FHPlus at any time in the future using a full application such as "Access NY Health Care" (DOH 4220).

The FPBP has fewer eligibility requirements than other programs. The non-financial requirements that apply are verification of age, identity, residency and citizenship/alien status. Finger imaging, the photo identification card requirement, drug/alcohol requirements and child support requirements do not apply to those individuals applying only for the FPBP. As such, any individual who is currently ineligible for cash assistance, Medicaid or FHPlus due to noncompliance with these requirements may be eligible for the FPBP.

The provisions of the Family Planning Extension Program (FPEP) continue. The eligibility requirements for FPBP and FPEP are somewhat different and are described in an August 25, 1998 "Dear Commissioner" letter. A woman who was eligible for Medicaid while she was pregnant is eligible for FPEP services for 26 months following the end of the pregnancy. There is no application for the FPEP. Therefore, if a woman does not recertify for Medicaid after the 60 day postpartum extension, she is still eligible for 24 months, regardless of income, resources or immigration status. A limited number of providers participate; the State Department of Health, Bureau of Women's Health, has a list. Payments to providers under the FPEP are administered by the Department's Bureau of Woman's Health.

C. Documentation Requirements

The documentation checklist that is part of the "Access NY Health Care Application" (DSS-4220) may be used for the FPBP application process. The documentation requirements of financial and non-financial factors generally follow those that apply to Medicaid and FHPlus eligibility. However, certain exceptions apply to minors living with their parents.

For applicants under age 21 living with their non-applying parents, age and citizenship requirements are modified in recognition that these applicants may have limited or no access to the documents that prove these items.

When an under 21 year old is not able to obtain verification of date of birth by providing a copy of his or her birth certificate, passport, official school records, or other documentation alternatives commonly accepted for Medicaid or FHPlus applicants, a statement by the minor attesting to his or her date of birth, and acknowledging that he or she is not able to provide other documentation, is acceptable. A sample "Declaration of Age" statement is attached as Attachment II.

All applicants must complete the citizenship portions of the FPBP application. When citizenship cannot be documented by under 21 year olds living with their parents, the statement in Section D of the FPBP application and the certification of citizenship under "Terms, Rights and Responsibilities" on the back of the application will suffice.

Once an applicant is determined eligible for the FPBP, eligibility will not be redetermined for 24 months, unless eligibility circumstances change, such as income increasing above 200 percent of the poverty level.

IV. Required Action

A. Application Process

Districts must provide for the initial intake and processing of applications for the FPBP. Districts must determine FPBP eligibility for individuals who are ineligible for Medicaid and FHPlus and who apply on the "Access New York Health Care" application (DOH-4220) or on the "Application for Temporary Assistance (TA)- Medical Assistance (MA)- Food Stamp Benefits (FS)- Services (S)- including Foster Care (FC)- Child Care Assistance (CC)" (LDSS-2921).

When a parent and teen(s) apply for Medicaid/FHPlus and are determined ineligible, FPBP eligibility will be determined for all applicants of child bearing age.

FPBP applicants must be informed by the interviewer of the benefits available under Medicaid and FHPlus and of their right to a Medicaid and FHPlus determination. If the reported income is below the Medicaid or FHPlus income standards, the individual/family should be encouraged to apply for Medicaid or FHPlus, and the application requirements must be explained. After this discussion, if applicants choose to apply for the FPBP only, they must complete the "Family Planning Benefit Program" application and sign the "Declination of Medicaid and Family Health Plus Eligibility Determinations" statement on the back of the application. These applicants must be advised that they may apply for Medicaid or FHPlus at any time in the future and that all FPBP participants will need to recertify every 24 months. (See Section IV.B. Recertification/Renewal Process of this ADM.)

Under 21 year olds who want to apply for family planning services, are living with their parents, and do not have parental financial information, and adults who choose not to apply for Medicaid and Family Health Plus must use the "Family Planning Benefit Program" application (Attachment I). Districts must accept FPBP only applications when individuals choose not to apply for Medicaid and Family Health Plus.

Workers should pay particular attention to confidentially concerns, i.e., entering applicant's mailing address in the Associated Name section on WMS. If the applicant is requesting confidentiality, instructions for completion of the application suggest that the applicant write "confidential" in the margin and circling the mailing address, if different from the applicant's address. However, if the application contains a different mailing address and/or the "Yes" box is checked in answer to the question, "Do you need these services kept confidential?", the application should be treated as confidential, regardless of whether the applicant circled the mailing address or wrote "confidential" in the margin.

If minors receiving Child Health Plus have confidentiality concerns about using their Child Health Plus coverage for family planning services, they should be allowed to enroll in FPBP.

Individuals receiving Medicaid, Child Health Plus A and Family Health Plus are not eligible for FPBP.

Individuals who have applied for Medicaid/Family Health Plus and been determined ineligible for Medicaid and Family Health Plus, must have their eligibility determined for FPBP. Individuals who are financially eligible for FPBP, but who choose not to participate in FPBP, must be sent the manual notice, "Notice of Decision on your Medical Assistance Application: Medicaid/Family Health Plus Denial/Family Planning Benefit Program Declination" (Attachment VI).

B. Recertification/Renewal Process

Eligibility for the FPBP must be redetermined every 24 months. As described in Section V. Systems Implications, the district will authorize the initial 12 months of coverage. The second 12 months of coverage will be generated systemically. Required renewal notification procedures will apply at the conclusion of the 24 month eligibility period.

C. Memorandum of Understanding

Family planning providers, local county health departments, and Prenatal Care Assistance Program (PCAP) providers can assist in the application process. Districts are encouraged to work with these entities to facilitate the processing of applications, including the delegation of the face-to-face interview. All applications taken by these family planning providers will be forwarded to the LDSS for final eligibility determinations.

To facilitate the application and interview process, the attached model Memorandum of Understanding (MOU) (Attachment III) has been developed for use by LDSS and family planning providers.

Included as an attachment to the MOU is the Confidentiality Agreement. Designated provider staff assisting the applicant in completing the application and obtaining documentation must sign the agreement and acknowledge that they understand the strict need for confidentiality. Also included as an attachment to the MOU is an Applicant Release Agreement that must be signed by the applicant and submitted with the application packet to the LDSS by the provider.

If an LDSS chooses to modify the MOU regarding procedures that are agreed to by the providers, the revised MOU must be submitted to and approved by State OMM. However, no change or deletion can be made to any paragraph that mentions confidentiality or release forms or signatures required on the confidentiality agreements or release forms.

D. Notices

For individuals determined eligible for the FPBP under either application, a manual acceptance notice must be sent. The "Notice of Decision on Your Medical Assistance Application (Family Planning Acceptance)" will be used when an individual has applied for Medicaid and FHPlus as well as the FPBP but is eligible only for the FPBP (see Attachment IV). The "Notice of Decision on Your Family Planning Application (Acceptance)" will be used when eligibility is determined for the FPBP only (see Attachment V). The "Notice of Decision on your Medical Assistance Application: Medicaid/Family Health Plus Denial/Family Planning Benefit Program Declination" (Attachment VI) will be used for individuals determined ineligible for Medicaid/Family Health Plus and who chose not to participate in FPBP. Local districts should make copies of these notices until a supply is printed and distributed.

Applicants determined ineligible for the FPBP must be notified with the appropriate Client Notice System (CNS) notice as described under Section V. Systems Implications.

V. Systems Implications

Systems support for the FPBP will be available in mid-November 2002. Further systems details may be found in the WMS/CNS Coordinator Letter dated October 31, 2002 and MBL Transmittal 02-3 dated October 24, 2002 associated with the November 18, 2002 (2002.3) systems migration.

Upstate Systems

For Case Type 20, "Medical Assistance (MA)",two new Individual Categorical Codes have been developed to identify individuals eligible for family planning services only. Categorical Code 68 is "Family Planning Only-FP" and Categorical Code 69 is "Family Planning Services Only - FNP" (singles and childless couples over 21). Categorical Code 68 must be used for individuals of child bearing age under age 21 since they always meet federal categorical requirements. Individuals aged 21 through 64 can have either Categorical Code depending on the

individual's circumstances, for example, a mother living with a 6 year old child or a certified disabled individual would be coded with Individual Categorical Code 68. A 34 year old single healthy man would be coded with Individual Categorical Code 69.

Coverage Code 18 will be used for the FPBP to provide only family planning services. Once system support is in place in mid-November, districts will need to authorize cases using Coverage Code 18, retroactive to October 1, 2002, if appropriate.

Certain individuals who are eligible for FPBP may also be eligible for spenddown if they have sufficient medical bills and have resources under the applicable resource level. If such individuals meet their spenddown, districts may upgrade coverage from Coverage Code 18 to MA Coverage Code 02 (Outpatient Only) for the months for which the spenddown has been met. WMS will return Coverage Code 18 for the remaining balance of the authorization period.

MBL Expanded Eligibility Code (EEC) "J" (Medicaid/Family Planning) will be added into EEC Code "B", which is the EEC Code entered when multiple standards may apply in a case. FHPlus Codes "F" (FHPlus for Families/19-20 Year Olds Living with Parents (133%)), "N" (FHPlus for 19-20 Year Olds Not Living with Parents (100%)) and "S" (FHPlus for Singles/Childless Couples (100%)) will also calculate eligibility for FPBP. EEC Code "K" (Family Planning Only) will be added to MBL when application is for Family Planning only, not for Medicaid or FHPlus. Comparison of income will be only to 200% FPL when Code "K" is used.

The "J" and "K" Codes are valid with Budget types 01, 02, 04, 05 and 06. The FPL for the two new codes is 200%. The MBL Expanded Screen will display "Family Planning Eligible" or "Family Planning Ineligible" and the net income figure for individuals eligible under Code "J" or "K".

The Welfare Management System (WMS) is not able to accommodate a 24 month authorization. FPBP cases should be authorized by the district for 12 months. WMS will automatically extend the authorization period for the second 12 months. At the end of the 24 months of family planning eligibility, the case will enter a recertification cycle and must be recertified.

The Client Notice System should be used for denials, discontinuances and undercare notices. CNS language has been revised to note ineligibility for the FPBP for financial reasons. Use appropriate CNS codes pertaining to the particular circumstances, for example, for denial reason code U35, "Excess Income, S/CC or FNP Parent", when income is over 200% FPL, language will also note ineligibility for the FPBP. Few CNS changes are expected as a result of implementation of FPBP. The new and revised CNS notices were released in the October 31, 2002"Dear WMS/CNS Coordinator" letter. Additional CNS notices are under development for the Spring 2003 migration.

New York City Systems

Systems capabilities for the FPBP will be developed in two phases. Phase I became operational November 18, 2002, retroactive to October 1, 2002, and Phase II will become operational early in 2003.

Phase I uses Presumptive Eligibility Case Type 21 for FPEP temporarily for systems reasons only; there is no presumptive eligibility. For Phase 2, Case Type 20 will be able to support FPBP andCase Type 21 will no longer be used for FPBP.

Phase I includes two new Categorical Codes for family planning. Categorical Code 68 is used for individuals eligible for Family Planning Services Only - FP and Categorical Code 69 uses for individuals eligible for Family Planning Services Only - FNP. Medicaid Coverage Code 18 (Family Planning Services Only) will be available and anew opening reason code 076 will be valid.

Detailed instruction will be provided.

VI. Effective Date

The effective date of this Administrative Directive is October 1, 2002.

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management

APPLICATION
FAMILY PLANNING BENEFIT PROGRAM

Please print clearly. Please ask for help if there is anything you do not understand.

SECTION A: CONTACT INFORMATION

Tell us who you are and how to contact you.

NAME First	Middle Initial	Last	Primary Language Spoken

Home Address	Street	Apt#	City	State	Zip Code	County

If you do not want to receive mail or a benefit card at your home address, give a different address below.

Mailing Address (if different)	Street	Apt#	City	State	Zip Code	County

Phone number(s) where you can be reached:

Is anyone in the household a veteran? If YES, Name:

Does anyone who is applying have family planning bills from the past three months? Yes ❒ No ❒
The Family Planning Benefit Program may be able to help pay them.

Do you need these services kept confidential? Yes ❒ No ❒

SECTION B: HOUSEHOLD INFORMATION

List the names of everyone applying. If you are applying, list yourself first. List other people living with you even if they are not applying. You must list your spouse and you may list your children.

	First Name, Middle Initial, Last Name (Use another page if you need to list more people)	Date of Birth (MM/DD/YY)	Sex M/F	Relationship to Person on Line 1	Is this person applying for family planning benefits (Yes/No)	**Applicants only** Social Security Number	**Applicants only** Race/Ethnic Group (See Codes)
01				Self			
02							
03							
04							

Race/ Ethnic Affiliation Codes: *(optional)*
B= Black or African American **W**= White **I**= American Indian or Alaskan Native **U**= Unknown
A= Asian **H**= Hispanic or Latino **P**= Native Hawaiian or other Pacific Islander

SECTION C: HOUSEHOLD INCOME

List the types of money and the amount received by anyone listed in Section B. Be sure to include earnings from work, child support payments, unemployment benefits, interest, Social Security Benefits, pensions, disability payments, money from relatives or friends or other payments.

Name of person working or receiving money	Type of income (example: wages)	How much does the person receive (before taxes)	How often is the income received? (weekly, every two weeks, monthly, other)

If no income, please explain how you are meeting your needs (for example, living with friend or relative):

Do you have to pay for child care (or for care of a disabled adult) in order to work or go to school? Yes ❒ No ❒

If yes	Name(s):	How much? $	How often? (example: weekly, monthly)

SECTION D: CITIZENSHIP

This information is needed for those people applying for family planning benefits.

Is everyone who is applying a U.S. citizen? (*If yes, skip to Section E*) Yes ❒ No ❒

If NO, please give the following information for anyone **applying** for family planning benefits who is not a U.S. citizen. Your answers to these questions will be kept completely confidential.

First Name, Middle Initial, Last Name	Does this person belong to any of the categories listed below? Check the appropriate box.			If A or B, on what date did the person enter the United States? (mm/dd/yy)
	A ❒	B ❒	None ❒	
	A ❒	B ❒	None ❒	

A.: Check A if the person is under one of the following categories:

Legal Permanent Resident (green card holder)
Asylee Refugee Amerasian Cuban/Haitian Entrant
Withholding of Deportation Parolee for at least one year
Conditional Entrant Some battered immigrants and/or children
Native American born in Canada who is at least 50% Native American

B.: Check B if the person is under one of the following categories:

Order of Supervision Stay of Deportation Suspension of Deportation
Voluntary Departure Deferred Action status Parolee for less than one year
Covered by an approved immediate relative petition
Properly filed or granted application for adjustment of status
Has lived continuously in the United States since before January 1, 1972
Living in the United States with the knowledge and permission or acquiescence of the INS and whose departure INS does not contemplate enforcing.

SECTION E: HEALTH INSURANCE

You may still be eligible even if you have other health insurance

Does anyone applying have Medicaid, Family Health Plus or Child Health Plus? If YES, give the name of anyone with coverage:

Does anyone have other health insurance that covers a person applying for the Family Planning Benefit Program Yes ❒ No ❒ Don't know ❒

If YES		
	Person(s) Covered:	
	Name of Policy Holder:	Group/Policy #
	Insurance Company Name:	Monthly Cost$

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for the Family Planning Benefit Program (FPBP). I agree to the release of personal and financial information from this application and any other information needed to determine eligibility. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

I understand that I must provide the information needed to prove my eligibility. If I have been unable to get the information, I will tell the social services district. The social services district may be able to help in getting the information.

I understand the FPBP may check the information given by me for this application. The state, social services district and provider who assist in completing this application will keep this information confidential according to 42 U.S.C. 1396a(a)(7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.

I understand that my eligibility for this program will not be affected by my race, color, disability, sex, or national origin. I also understand that depending on the requirements of this program, my age or citizenship status may be a factor in whether or not I am eligible.

I understand that anyone who knowingly lies or hides the truth in order to receive services under this program is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and be given civil penalties.

ASSIGNMENT OF RIGHTS FOR MEDICAL SUPPORT AND THIRD PARTY PAYMENT

I understand that FPBP does not pay medical expenses that insurance or another person is supposed to pay, unless there is good cause not to use other insurance. All persons applying for FPBP are required to give to the Medicaid agency any rights they may have to medical support or other insurance payments for family planning services. When I sign this application for myself, or for another person for whom I can legally give away rights, I am giving to the Medicaid agency all of my rights to receive medical support and third party payments for family planning services for the entire time I am on Medicaid.

REIMBURSEMENT OF MEDICAL EXPENSES

I understand that I have a right as part of my FPBP application to request reimbursement of expenses I paid for covered family planning services and supplies received during the three month period prior to the month of my application, but no earlier than October 1, 2002. After the date of my application, reimbursement of covered family planning services and supplies will only be available if obtained from Medicaid-enrolled providers.

SOCIAL SECURITY NUMBER (SSN)

I understand that I must give my SSN in order to receive FPBP. This is required by section 1137(a) of the Social Security Act and the Medicaid regulations (42 CFR 435.910 and 42 U.S.C. 1320b-7(a)). The FPBP will use the SSN to verify my income, eligibility, and the amount of medical assistance payments made on my behalf. The information may be matched with the records in other agencies, such as the Social Security Administration or the Internal Revenue Service.

CONFIDENTIALITY STATEMENT

All of the information you provide to us will remain confidential. The only people who will see this information are the state or local agencies and the person assisting you in completing the application who need to know this information in order to determine if you are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies that need this information.

I certify that I am a U.S. citizen or national, or an alien with satisfactory immigration status. The social services district can assist me in determining my status if I request help.

Date_____ Applicant's Signature X_____

Immigration Information: The Immigration and Naturalization Service (INS) has said that enrollment in Medicaid CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member or travel in and out of the country (except if Medicaid pays for long term care in a place like a nursing home or psychiatric hospital). **The State will not report any information on this application to the INS.**

I certify that I have read and understand the Terms, Rights and Responsibilities above. I certify under penalty of perjury that everything on this application is the truth as best I know.

Date_____ Applicant's Signature X_____ Spouse's Signature (if applying)_____

Declination of Medicaid and Family Health Plus Eligibility Determinations:

I, _____, have been informed of the benefits available under Medicaid and Family Health Plus. I choose not to apply for Medicaid and Family Health Plus at this time, and have requested an eligibility determination for the Family Planning Benefit Program only. I understand that I may apply for these other programs in the future if I wish.

Date_____ Applicant's Signature X_____

Provider/Medicaid Staff Signature _____

IF AFTER READING AND COMPLETING THIS FORM, YOU DECIDE THAT YOU DO NOT WANT TO APPLY FOR THE FAMILY PLANNING BENEFIT PROGRAM, SIGN your name below:

Date_____ I consent to withdraw my application: X_____

FOR OFFICE USE ONLY:

To be completed by the person assisting with the application:

Signature of Person Who Obtains Eligibility Information: Employed By:

X_____ _____

To be completed by the Local Social Services District:

Eligibility Determined by: Date: Eligibility Approved By: Date:

_____ _____ _____ _____

Center Office: Application Date: Unit ID: Worker ID: Ver:

Case Name: District: Case Type: Case No:

Effective Date: MA Disposition Reason Code: Proxy: Reg. No.

INSTRUCTIONS
FAMILY PLANNING BENEFIT PROGRAM APPLICATION

Confidentiality Statement:
All of the information you provide on this application will remain confidential. The only people who will see this information are the enrollment facilitators and the state or local agencies and family planning providers who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies or family planning providers who need this information.

INSTRUCTIONS. These are the instructions for completing the Family Planning Benefit Program application. This application is for people applying for the Family Planning Benefit Program (FPBP) only.

Applicants must sign the declination on the application stating that they do not want their eligibility determined for Medicaid or Family Health Plus. You may apply for Medicaid or Family Health Plus any time in the future. These programs cover many other health care services in addition to family planning services. If you want your eligibility determined for Medicaid or Family Health Plus, you must complete the "Access NY Health Care" (DOH-4220) application.

PLEASE READ the entire application and instructions before you fill out the application. You may attach an additional sheet of paper if there is not enough room for your answers on the application.

SECTION A: Contact Information

In this section, we ask for the applicant's name and information about how to contact the applicant. The home address is where the persons applying for the FPBP live. The mailing address, if different, is where the Common Benefit card, all notices and other information will be sent.

Applicants can receive confidential family planning services. If you want confidential notification, check "YES" after the question, "Do you need these services kept confidential?". If you use a different mailing address to insure confidentiality, complete the next section "Mailing Address (if different)", circle the mailing address and write "Confidential" in the margin next to it.

Also, enter whether anyone in the household is a veteran. Indicate whether you or anyone who is applying has unpaid or recently paid family planning bills from the past three months. If so, the FPBP may be able to help pay them.

SECTION B: Household Information

List the names of all the people living with you who want to apply for FPBP. List yourself first. List other people living with you even if they are not applying. You must list your spouse and you may list your children. Fill out the information requested for each household member:

- Indicate whether the person listed on the line is also applying for FPBP (enter "yes" or "no").
- A social security number must be provided for all persons applying. If anyone applying does not have a social security number, they must apply for one. Applicants may attest to their social security number.
- Race/Ethnic Group – this information is optional. It is asked to make sure all people have access to the program. If you fill out this information, use one of the codes shown on the application that best describes the person's race or ethnic background.

SECTION C: Household Income

In this section, list all types of income and the amount received by the people you listed in Section B. Be sure to include earnings from work, child support payments, unemployment benefits, interest, Social Security Benefits, pensions, disability payments, money from relatives or friends or other payments.

- If the household has no income, please explain how the applicants are being supported.
- Indicate if you have to pay for child care or for care of a disabled adult in order to work or go to school. Check the appropriate box. If yes, give the name of the individual(s) who receives the care, how much you pay for the care, and how often you pay the amount listed (for example weekly, monthly).

SECTION D: Citizenship

This information is needed for those people applying for family planning benefits. The State will not report any information on this application to the INS.

SECTION E: Health Insurance

It is important to tell us whether anyone in your household has health insurance or is covered by someone else's insurance, because:

- For certain applicants, we will subtract the cost of the health insurance from your income;
- For future medical bills, it helps us determine which insurance should pay first.

If anyone in the household has Medicaid, Family Health Plus or Child Health Plus, give the name(s) of the household member(s). This may help us reduce paperwork for you.

If anyone in the household has other health insurance coverage, provide the information requested.

If you do not know or cannot get the health insurance information, please check “Don’t know”. If you want this application and receipt of FPBP to be kept confidential from the health insurance policyholder, please write or print in large letters “Good Cause” across Section E on the front of the application.

Attachment II

Family Planning Benefit Program

Declaration of Age for Minors

This form should only be filled out by **minors under age 21** who have no other documents to show proof of birth.

I (print)_____certify that I do not have and am not able to obtain any of the following documentation:

- Birth certificate
- Baptismal certificate
- Hospital records (of my birth)
- School records (with my date of birth)
- Naturalization certificate
- Adoption records (if I was adopted)
- Driver's license

I do not have any other way to verify my date of birth, which is _____. I certify that this information is true and correct. I understand that this information is to be used to determine eligibility for the Family Planning Benefit Program and that program officials may verify information on this form. I have read and understand my rights and responsibilities as indicated on my application.

Signature:_____ Date:_____

Attachment III

MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding between _____County Department of Social Services (DSS) and _____, (local county health department, publicly supported family planning clinic, or a Prenatal Care Assistance Program (PCAP) provider; hereafter, referred to as the provider) that services _____ County residents in which provider staff accept applications for:

- ❑ Medicaid, Family Health Plus (FHPlus) and Family Planning Benefit Program (FPBP); or
- ❑ FPBP only.

All applications taken at these sites will be forwarded to the local social services district for final eligibility determinations.

Whereas, Social Services Law 366(1)(a)(11) provides reimbursement for family planning services only:

The parties agree as follows:

A. The DSS agrees to:

1. Supply designated provider staff with applications, including:
   _____ the "Family Planning Benefit Program" for applicants who have declined a Medicaid and FHPlus determination;
   _____ the Applicant Release Agreement;
   _____ the "Access NY Health Care" application (DOH-4220) for individuals applying for Medicaid, FHPlus, and FPBP, if this agreement specifies that the provider will accept applications and documents for all covered programs.
2. Supply for distribution to applicants the "Need Help Paying for Medical Care?" brochure (DOH-3360), and "Family Health Plus, New York State's Health Insurance Program for Adults" booklet (DOH-5002).
3. Provide training by district staff to designated provider staff in interviewing techniques and the kinds of information or documents the applicant must provide to verify eligibility.
4. Provide training on the general eligibility requirements for Medicaid, FHPlus and the FPBP.
5. Advise the provider staff of relevant changes in Medicaid regulations and procedures in a timely manner.
6. Follow up on applications after submission by the providers. If the DSS needs additional documentation/verification, it may request that the provider get the information.
7. Notify applicants of the Medicaid/FHPlus or FPBP eligibility decision and forward a copy of the notice to the provider.
8. Give the provider the name(s) of a contact person, a phone number and a fax number, if available, of the contact person at DSS.
9. Cooperate with the provider to establish reasonable procedures to accomplish the tasks described in this document.

B. For the purpose of this program, the Provider will:

1. Designate an interviewer(s) and notify DSS in writing of the name(s), title(s) and qualifications of the person(s) and names of any backup or replacement staff that will be performing eligibility interviews.
2. Notify the DSS in writing of the name(s), title(s) and telephone numbers of the provider staff who will be accepting applications.
3. Retain documentation of the name(s), title(s), and telephone number of staff assisting individuals to complete applications.
4. Obtain a signed Applicant Release Agreement prior to obtaining confidential applicant information.
5. Explain to the applicant the health care programs that may be available to them, specifically Medicaid, FHPlus and FPBP. Provide all applicants the following information: "Need Help Paying for Medical Care?" brochure (DOH-3360), "Family Health Plus, New York State's Health Insurance Program for Adults" booklet (DOH-5002) and the "Health Insurance and Nutrition Access NY Health Care" informational sheet. Designated staff shall review this information with the applicant and help the applicant make an informed choice of applying for all programs or the FPBP only. Advise applicants who want to apply for FPBP only that they may apply for Medicaid or FHPlus at anytime.
6. Provide applicants with the entire application package and assist the applicant in completing the forms as needed.
7. Conduct a face-to-face interview with the applicant or the applicant's representative and obtain as much documentation as possible of all statements on the application form "Access NY Health Care"(DOH-4220) if the applicant is applying for Medicaid, FHPlus and FPBP, or "Family Planning Benefit Program" if the applicant has chosen not to apply for Medicaid or FHPlus. All necessary documentation that is not submitted at the interview must be entered on the Documentation Checklist of the DOH-4220. Provide a copy of the Documentation Checklist to the applicant; notify the applicant of any missing documentation and the due date for submission of documentation. Assist the individual as needed to secure information.
8. Refer any applicant who wants to apply for any other social services program to the DSS office.
9. Provide the original application with the completed Applicant Release Agreement and a photocopy of all documentation required, to DSS on a timely basis using the agreed upon procedures. All completed "Family Planning Benefit Program" applications must include the applicant's signature under the "Declination of Medicaid and Family Health Plus Eligibility Determinations" statement.
10. Maintain a log that shows the applicant's name, date of interview and date on which the application was provided to DSS.
11. Healthcare providers must provide written information to clients on how to access primary care services at Federally Qualified Health Centers (FQHC) and other providers, including their locations and phone numbers.
12. Keep confidential all information obtained while acting as a provider to facilitate the filing of an application.

The unauthorized release of information collected can result in termination of this agreement for violation of the confidentiality requirements cited below and in Section 136 of the Social Services Law and can result in potential legal action. All persons who are designated to take applications and assist applicants as agreed to by the DSS must sign the confidentiality agreement provided by the DSS.

The Medicaid Confidential Data (MCD) includes, but is not limited to, names and addresses of Medicaid applicants/recipients, the medical services provided, social and economic conditions or circumstances, the Department of Health's evaluation of personal information, medical data, including diagnosis and past history of disease and disability, any information regarding income eligibility and amount of Medicaid payment, income information, and/or information regarding the identification of third parties. Each element of Medicaid confidential data is confidential regardless of the document or mode of communication or storage in which it is found.

Note that this Memorandum of Understanding involves Medicaid Data, which is confidential pursuant to New York Medicaid State Plan requirements, 42 U.S.C. Section 1396 a(a)(7) and federal regulations at 42 CFR Sections 431.300 et seq.

Also, pursuant to Section 367b (4) of the New York State Social Services Law, information relating to persons APPLYING FOR Medicaid shall be considered confidential and shall not be disclosed to persons or agencies without the prior written approval of the New York State Department of Health.

AIDS/HIV Related Confidentiality Restrictions:

Also note that MCD may contain HIV related confidential information, as defined in Section 2780 (7) of the New York State Public Health Law. As required by New York Public Health Law Section 2782 (5), the New York State Department of Health hereby provides the following notice:

HIV/AIDS NOTICE

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

The provider agrees that any further disclosure of MCD requires the prior, written approval of the New York State Department of Health (NYSDOH), Medicaid Confidential Data Review Committee (MCDRC). The provider will require and ensure that the approved agreement, contract or document contains the above Notice and a statement that any other party may not disclose the MCD without the prior, written approval of the NYSDOH MCDRC.

Any provider participating in the program who consistently fails to meet minimum performance standards as determined by the DSS may be ineligible to continue as a designated provider to assist individuals in the application process.

The participating provider may withdraw from this program and terminate this Memorandum of Understanding upon 60 days written notice to the DSS. The DSS may terminate this Memorandum of Understanding upon 60 days written notice to the participating provider.

_____	_____
Provider Representative	County Department of Social Services
_____	_____
Title	Title
_____	_____
Date	Date

CONFIDENTIALITY AGREEMENT

I,_____,(title)_____
at or on behalf of the _____ (provider, a local health department, publicly supported family planning clinic, or a Prenatal Care Assistance Program (PCAP)) have been designated to take applications for Medicaid, Family Health Plus (FHPlus), and the Family Planning Benefit Program (FPBP), or for FPBP only, on behalf of the _____County Department of Social Services. I understand that all communications, information, and documents received by me in the course of accepting the Medicaid, FHPlus and FPBP application and assisting the applicant is confidential and may not be disclosed by me to unauthorized personnel or used for any purpose other than determining eligibility for Medicaid, FHPlus and the FPBP.

I have read the attached Confidentiality Statement and understand that any violation of the provisions of this agreement is unlawful and may subject me to loss of my status as a designated interviewer as well as any other penalties prescribed by law.

_____
Signature

_____
Print Full Name

_____
Date

_____
Witness

Confidentiality Statement

Medicaid Confidential Data (MCD) includes, but is not limited to, names and addresses of Medicaid applicants/recipients, the medical services provided, social and economic conditions or circumstances, the Department of Health's evaluation of personal information, medical data, including diagnosis and past history of disease and disability, any information regarding income eligibility and amount of Medicaid payment, income information, and/or information regarding the identification of third parties. Each element of Medicaid confidential data is confidential regardless of the document or mode of communication or storage in which it is found.

Note that this Memorandum of Understanding involves Medicaid Data, which is confidential pursuant to New York Medicaid State Plan requirements, 42 U.S.C Section 1396 a(a) (7) and federal regulations at 42 CFR Sections 431.300 et seq.

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The providers agree that any further disclosure of MCD requires the prior, written approval of the New York State Department of Health (NYSDOH), Medicaid Confidential Data Review Committee (MCDRC). The Providers will require and ensure that the approved agreement, contract or document contains the above Notice and a statement that any other party may not disclose the MDC without the prior, written approval of the NYSDOH MCDRC.

Applicant Release Agreement

I agree that the information on this application may be shared only with the State Medicaid Program, New York State Family Planning Benefit Program, the local social services districts, and the provider providing the application assistance. I understand that this information is being shared for the purpose of determining my eligibility for Medicaid.

_____ _____

Date Applicant's Signature

ATTACHMENT IV

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION

(FAMILY PLANNING ACCEPTANCE)

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.

We have accepted your application dated _____ for the Family Planning Benefit Program effective _____.

This is because your net income (gross income less Medical Assistance deductions) is at or below $_____ (200% of the Federal Poverty Level), which is the Medical Assistance income limit for these services. Please look at the budget calculation section to see how we figured your income.

However, (name(s))_____ is not eligible for the Family Planning Benefit Program because of age.

This means Medical Assistance will pay for family planning services only. Family planning services are services that may help prevent or reduce unwanted pregnancies. The family planning service package includes certain prescription and non-prescription drugs, medical supplies, sterilization and medical counseling. Call **1-800-541-2831** for a list of Family Planning Providers in your area.

For individuals over age 19, we evaluated your eligibility for Family Health Plus.

You were not eligible for full Medical Assistance or Family Health Plus for the reasons noted below:

- ❑ You were not eligible for Family Health Plus because your gross income of $_____ is over the Family Health Plus income limit of $_____.

- ❑ You were not eligible for Medical Assistance because:
  - □ Your net income (gross income less Medical Assistance deductions) of $_____ is over the Medical Assistance income limit of $_____. The amount over the income limit is called excess income or spenddown. Please see the attached "Explanation of the Excess Income Program".
  - □ You told us your countable resources are over the Medical Assistance resource limit of $_____. The amount over the resource limit is called excess resources or spenddown. There is no resource limit for the Family Planning Benefit Program.
  - □ SPENDDOWN ELIGIBLES ONLY:
    At the time of your interview for medical insurance coverage, the options of receiving either the Family Planning Benefit Program or Medical Assistance with a spenddown were explained to you. You chose to participate in the Family Planning Benefit Program rather than Medical Assistance with a spenddown. If you accumulate enough medical bills to meet your spenddown of $_____, contact your worker. If you choose to spenddown, you will have to verify your resources, if you have not already done so, since there is a resource limit for Medicaid.

- ❑ You were not eligible for Medical Assistance or Family Health Plus because _____.

- ❑ Persons who are ages 21 through 64, and are not pregnant or certified blind or disabled or caring for their related children under 21 years of age, must meet the requirements of the Public Assistance Program in order to be eligible for Medical Assistance.
  - □ Your gross income of $_____ is over 185% of the Public Assistance Standard of Need of $_____.
  - □ Your net income (gross income less Medical Assistance deductions) of $_____ is over the Public Assistance Standard of Need of $_____.

Children up to age 19 may be eligible for Child Health Plus B. Call 1-800-698-4543 for information.

If you do not want Family Planning services for yourself or anyone else you applied for, let your worker know.

This decision is based on Regulations 18 NYCRR 360-4.1, 4.7 and 4.8 and Sections 366(1) (a) (11) and 369-ee of Social Services Law.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, 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

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

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

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 Hearing, 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_____

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 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 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 on 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.

ANEXO IV

AVISO DE RESOLUCIÓN SOBRE SU SOLICITUD DE ASISTENCIA MÉDICA

(ACEPTACIÓN DE PLANIFICACIÓN FAMILIAR)

FECHA DEL AVISO:		NOMBRE Y DIRECCION DE LA AGENCIA/CENTRO U OFICINA DE DISTRITO
NUMERO DE CASO	NUMERO CIN	
NOMBRE DEL CASO (Y Nombre del C/O Si Esta Presente) Y DIRECCION		NO. DE TELEFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA _____ - **O** para Conferencia con la Agencia _____ informacion y asistencia Sobre Vista Imparcial _____ Acceso a Archivos/Records _____ informacion sobre Asistencia Legal _____

OFICINA NO.	UNIDAD NO.	NO. del Trabajador(a)	NOMBRE DEL TRABAJADOR(A) O DE LA UNIDAD	NO. DE TELEFONO

Hemos aceptado su solicitud fechada el _____ para el Programa de Beneficios para la Planificación Familiar, a partir del _____.

Esto se debe a que sus ingresos netos (ingreso bruto menos las deducciones por Asitencia Médica) son inferiores o iguales a $_____ (200% del Índice Federal de Porbeza), lo que constituye el límite de ingresos de Asistencia Médica para este tipo de servicios. Por favor, consulte la sección de cálculo de presupuestos para ver cómo estimamos sus ingresos.

No obstante, (nombre(s))_____ no califica(n) para el Programa de Beneficios para la Planificación Familiar debido a su(s) edad(es).

Esto significa que Asistencia Médica pagará solamente por los servicios de planificación familiar. Los servicios de planificación familiar son servicios que pueden ayudarlo a prevenir o reducir el número de embarazos no deseados. El paquete de servicios de planificación familiar incluye ciertos medicamentos, con y sin prescripción médica, suministros médicos, esterilización y asesoramiento médico. Llame al **1-800-541-2831** para solicitar un listado de proveedores de Planificación Familiar en su área.

Para aquellas personas mayores de 19 años de edad, hemos evaluado su elegibilidad para Family Health Plus.

Usted no calificó para Asistencia Médica completa o Family Health Plus por las razones que se citan debajo:

- ☐ No calificó para Family Health Plus porque su ingreso bruto de $_____ está por encima del límite de ingresos de Family Health Plus de $_____.

- ☐ No calificó para Asistencia Médica porque:
  - ☐ Sus ingresos netos (ingreso bruto menos las deducciones por Asistencia Médica) de $_____ están por encima del límite de ingresos de Asistencia Médica de $_____. La cantidad por encima del límite de ingresos se llama excedente de ingresos o responsabilidad económica del paciente. Por favor, consulte el documento adjunto "Explicación del Programa de Excedente de Ingresos".
  - ☐ Usted nos explicó que sus recursos contables están por encima del límite de recursos de Asistencia Médica de $_____. La cantidad por encima del límite de recursos se llama excedente de recursos o responsabilidad económica del paciente. No existe un límite de recursos para el Programa de Beneficios para la Planificación Familiar.

  - ☐ SOLAMENTE PARA ELEGIBLES DE RESPONSABILIDAD ECONÓMICA:
    En el momento de su entrevista para la cobertura de seguro médico, se le explicaron las opciones para recibir tanto el Programa de Benefiicios para la Planificación Familiar como Asistencia Médica con una responsabilidad económica. Usted eligió participar en el Programa de Benefiicios para la Planificación Familiar, y no así en Asistencia Médica con responsabilidad económica. Si usted acumula suficientes cuentas médicas para cubrir su responsabilidad económica de $_____, contacte a su asistente social. Si usted opta por la responsabilidad económica, deberá verificar sus recursos, si no lo ha hecho aún, ya que existe un límite de recursos para Medicaid.

- ☐ Usted no calificó para Asistencia Médica o Family Health Plus porque _____.

- ☐ Aquellas personas entre 21 y 64 años de edad, que no estén embarazadas ni sean declaradas ciegas o discapacitadas, o que no tengan a su cargo hijos menores de 21 años, deberán cumplir con los requisitos del Programa de Asistencia Pública a los efectos de calificar para Asistencia Médica.
  - ☐ Su ingreso bruto de $_____ está por encima del 185% del Estándar de Necesidad de Asistencia Pública de $_____.

  - ☐ Sus ingresos netos (ingreso bruto menos las deducciones por Asistencia Médica) de $_____ están por encima del Estándar de Necesidad de Asistencia Pública de $_____.

Los menores de hasta 19 años de edad pueden calificar para Child Health Plus B. Llame al 1-800-698-4543 para solicitar información.

Si no desea los servicios de Planificación Familiar para usted o para cualquier otra persona para quien los haya solicitado, hágaselo saber a sus asistente social

Esta decisión fue tomada basándose en las Normas 18 NYCRR 360-4.1, 4.7 y 4.8 y en las Secciones 366(1) (a) (11) y 369-ee de la Ley de Servicios Sociales.

LAS NORMAS EXIGEN QUE USTED NOTIFIQUE A ESTE DEPARTAMENTO DE INMEDIATO SOBRE CUALQUIER CAMBIO EN SUS NECESIDADES, RECURSOS, ORGANIZACIÓN DE VIDA O DIRECCIÓN

USTED TIENE DERECHO A APELAR ESTA DECISIÓN
ASEGÚRESE DE LEER EL RESTO DE ESTE AVISO RESPECTO DE CÓMO APELAR ESTA DECISIÓN

DERECHO A UNA CONFERENCIA: Usted puede tener una conferencia para revisar estas acciones. Si usted desea una conferencia, debe solicitar una tan pronto como sea posible. En la conferencia, si descubrimos que tomamos la decisión equivocada o si, debido a información que usted proporcione decidimos cambiar nuestra decisión, tomaremos acción correctiva y le proporcionaremos un nuevo aviso. Usted puede solicitar una conferencia llamándonos al número que aparece en la primera página de este aviso o enviándonos una petición por escrito a la dirección que se menciona en la parte superior de la portada de este aviso. Este número se utiliza sólo para solicitar una conferencia. ***No es la manera de solicitar una audiencia justa (fair hearing, en inglés).*** Si solicita una conferencia usted aún tiene derecho a una audiencia justa. Lea más adelante acerca de la información de audiencia justa.

DERECHO A UNA AUDIENCIA JUSTA: Si usted piensa que la acción anterior está equivocada, usted puede solicitar una audiencia justa Estatal:

(1) Llamando por teléfono: (POR FAVOR TENGA A LA MANO ESTE AVISO CUANDO LLAME)

Si vive en: La Ciudad de Nueva York (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

Si vive en: Los Condados de Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans o Wyoming: (716) 852-4868

Si vive en: Los Condados de Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne o Yates: (716) 266-4868

Si vive en: Los Condados de Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins o Tioga: (315) 422-4868

Si vive en: Los Condados de Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington o Westchester: (518) 474-8781

Si vive en: Los Condados de Nassau o Suffolk: (516) 739-4868

Ó

(2) **Escribiendo:** Enviando una copia de este aviso **debidamente llenado**, a la Oficina de Audiencias Administrativas de la Oficina de Asistencia Temporal y de Discapacidades del Estado de Nueva York a la siguiente dirección: Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Por favor conserve una copia para usted.

Deseo una audiencia justa. La acción de la Agencia está equivocada debido a:

_____

_____

_____

Firma del Cliente: _____ Fecha: _____

USTED TIENE 60 DÍAS DESPUÉS DE LA FECHA DE ESTE AVISO PARA SOLICITAR UNA AUDIENCIA JUSTA

Si usted solicita una audiencia justa, el Estado le enviará un aviso informándole de la hora y el lugar de la audiencia. Usted tiene derecho a que un asesor jurídico, un familiar, un(a) amigo(a) u otra persona lo(a) represente o a representarse a sí mismo(a). Durante la audiencia usted, su abogado u otro representante tendrán la oportunidad de presentar evidencia por escrito y verbal para demostrar por qué no se debe tomar la acción, así como también la oportunidad de cuestionar a cualquier persona que comparezca durante la audiencia. También tiene derecho a presentar testigos para que hablen en su favor. Usted debe traer a la audiencia cualquier documento, como por ejemplo, este aviso, talones de sueldo, recibos, facturas médicas, facturas de calefacción, verificación médica, cartas, etc. que puedan ser útiles para presentar su caso.

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, es posible que usted pueda obtener dicha asistencia comunicándose con la Sociedad de Asistencia Legal local u otro grupo defensor legal. Usted puede localizar a la Sociedad de Asistencia Legal (Legal Aid Society, en inglés) o grupo defensor más cercano revisando las Páginas Amarillas de su directorio telefónico bajo el título “Lawyers” (que significa “Abogados”) o llamando al número que se indica al frente de este aviso.

ACCESO A SU EXPEDIENTE Y A COPIAS DE LOS DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene derecho a revisar su archivo de caso. Si llama o nos escribe, le proporcionaremos copias gratuitas de los documentos de su archivo que nosotros le proporcionaremos al oficial de audencia durante la audiencia justa. También, si usted llama o nos escribe, le proporcionaremos copias gratuitas de otros documentos de su archivo que pensemos que usted puede necesitar para prepararse para su audiencia justa. Para solicitar documentos o para determinar cómo revisar su archivo, llámenos al número de teléfono de la Sección de Acceso a Archivos (Record Access, en inglés) que se encuentra en la parte superior del frente de este aviso o escríbanos a la dirección impresa en la parte superior del frente de este aviso.

Si usted desea obtener copias de los documentos de su archivo de caso, debe solicitarlas por anticipado. Se le proporcionarán en un tiempo razonable antes de la fecha de la audiencia. Los documentos se le enviarán por correo únicamente si usted específicamente solicita que se le envíen por correo.

INFORMACIÓN: Si usted desea información adicional acerca de su caso, cómo solicitar una audiencia justa, cómo revisar su archivo o cómo obtener copias adicionales de documentos, por favor llámenos a los números de teléfono que se mencionan en la parte superior del frente de este aviso o escríbanos a la dirección impresa en la parte superior del frente de este aviso.

ATTACHMENT V

NOTICE OF DECISION ON YOUR FAMILY PLANNING APPLICATION
(ACCEPTANCE)

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.

We have accepted your application dated _____ for the Family Planning Benefit Program effective _____.

When you applied for the Family Planning Benefit Program, you indicated that you did not want to apply for Medical Assistance and Family Health Plus. This means Medical Assistance will pay for family planning services only.

This is because your net income (gross income less Medical Assistance deductions) is at or below $_____ (200% of the Federal Poverty Level), which is the Medical Assistance income limit for these services.

Please look at the budget calculation section to see how we figured your income.

Family planning services are services that may help prevent or reduce unwanted pregnancies. The family planning service package includes certain prescription and non-prescription drugs, medical supplies, sterilization and medical counseling. Call **1-800-541-2831** for a list of Family Planning Providers in your area.

This decision is based on Section 366(1) (a) (11) of the Social Services Law.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, 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

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

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

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 Hearing, 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_____

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 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 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 on 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.

ANEXO V

AVISO DE RESOLUCIÓN SOBRE SU SOLICITUD DE PLANIFICACIÓN FAMILIAR

(ACEPTACIÓN)

FECHA DEL AVISO:	NOMBRE Y DIRECCION DE LA AGENCIA/CENTRO U OFICINA DE DISTRITO
NUMERO DE CASO / NUMERO CIN	
NOMBRE DEL CASO (Y Nombre del C/O Si Esta Presente) Y DIRECCION	NO. DE TELEFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA _____ - **O** para Conferencia con la Agencia _____ informacion y asistencia Sobre Vista Imparcial _____ Acceso a Archivos/Records _____ informacion sobre Asistencia Legal _____

OFICINA NO.	UNIDAD NO.	NO. del Trabajador(a)	NOMBRE DEL TRABAJADOR(A) O DE LA UNIDAD	NO. DE TELEFONO

Hemos aceptado su solicitud fechada el _____ para el Programa de Beneficios para la Planificación Familiar, a partir del _____.

Cuando usted solicitó el Programa de Beneficios para la Planificación Familiar, usted indicó que no deseaba solicitar Asistencia Médica y Family Health Plus. Esto significa que Asistencia Médica pagará solamente por los servicios de planificación familiar.

Esto se debe a que sus ingresos netos (ingreso bruto menos las deducciones por Asistencia Médica) son inferiores o iguales a $_____ (200% del Índice Federal de Pobreza), lo que constituye el límite de ingresos de Asistencia Médica para estos servicios.

Por favor consulte la sección de cálculo de presupuestos para ver cómo estimamos sus ingresos.

Los servicios de planificación familiar son servicios que pueden ayudarlo a prevenir o reducir el número de embarazos no deseados. El paquete de servicios de planificación familiar incluye ciertos medicamentos, con y sin prescripción médica, suministros médicos, esterilización y asesoramiento médico. Llame al **1-800-541-2831** para solicitar un listado de proveedores de Planificación Familiar en su área.

Esta decisión fue tomada basándose en la Sección 366(1) (a) (11) de la Ley de Servicios Sociales.

LAS NORMAS EXIGEN QUE USTED NOTIFIQUE A ESTE DEPARTAMENTO DE INMEDIATO SOBRE CUALQUIER CAMBIO EN SUS NECESIDADES, RECURSOS, ORGANIZACIÓN DE VIDA O DIRECCIÓN

USTED TIENE DERECHO A APELAR ESTA DECISIÓN
ASEGÚRESE DE LEER EL DORSO DE ESTE AVISO RESPECTO DE CÓMO APELAR ESTA DECISIÓN

DERECHO A UNA CONFERENCIA: Usted puede tener una conferencia para revisar estas acciones. Si usted desea una conferencia, debe solicitar una tan pronto como sea posible. En la conferencia, si descubrimos que tomamos la decisión equivocada o si, debido a información que usted proporcione decidimos cambiar nuestra decisión, tomaremos acción correctiva y le proporcionaremos un nuevo aviso. Usted puede solicitar una conferencia llamándonos al número que aparece en la primera página de este aviso o enviándonos una petición por escrito a la dirección que se menciona en la parte superior de la portada de este aviso. Este número se utiliza sólo para solicitar una conferencia. ***No es la manera de solicitar una audiencia justa (fair hearing, en inglés).*** Si solicita una conferencia usted aún tiene derecho a una audiencia justa. Lea más adelante acerca de la información de audiencia justa.

DERECHO A UNA AUDIENCIA JUSTA: Si usted piensa que la acción anterior está equivocada, usted puede solicitar una audiencia justa Estatal:

(1) Llamando por teléfono: (POR FAVOR TENGA A LA MANO ESTE AVISO CUANDO LLAME)

Si vive en: La Ciudad de Nueva York (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

Si vive en: Los Condados de Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans o Wyoming: (716) 852-4868

Si vive en: Los Condados de Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne o Yates: (716) 266-4868

Si vive en: Los Condados de Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins o Tioga: (315) 422-4868

Si vive en: Los Condados de Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington o Westchester: (518) 474-8781

Si vive en: Los Condados de Nassau o Suffolk: (516) 739-4868

Ó

(2) **Escribiendo:** Enviando una copia de este aviso **debidamente llenado**, a la Oficina de Audiencias Administrativas de la Oficina de Asistencia Temporal y de Discapacidades del Estado de Nueva York a la siguiente dirección: Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Por favor conserve una copia para usted.

Deseo una audiencia justa. La acción de la Agencia está equivocada debido a:

_____

_____

_____

Firma del Cliente: _____ Fecha: _____

USTED TIENE 60 DÍAS DESPUÉS DE LA FECHA DE ESTE AVISO PARA SOLICITAR UNA AUDIENCIA JUSTA

Si usted solicita una audiencia justa, el Estado le enviará un aviso informándole de la hora y el lugar de la audiencia. Usted tiene derecho a que un asesor jurídico, un familiar, un(a) amigo(a) u otra persona lo(a) represente o a representarse a sí mismo(a). Durante la audiencia usted, su abogado u otro representante tendrán la oportunidad de presentar evidencia por escrito y verbal para demostrar por qué no se debe tomar la acción, así como también la oportunidad de cuestionar a cualquier persona que comparezca durante la audiencia. También tiene derecho a presentar testigos para que hablen en su favor. Usted debe traer a la audiencia cualquier documento, como por ejemplo, este aviso, talones de sueldo, recibos, facturas médicas, facturas de calefacción, verificación médica, cartas, etc. que puedan ser útiles para presentar su caso.

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, es posible que usted pueda obtener dicha asistencia comunicándose con la Sociedad de Asistencia Legal local u otro grupo defensor legal. Usted puede localizar a la Sociedad de Asistencia Legal (Legal Aid Society, en inglés) o grupo defensor más cercano revisando las Páginas Amarillas de su directorio telefónico bajo el título "Lawyers" (que significa "Abogados") o llamando al número que se indica al frente de este aviso.

ACCESO A SU EXPEDIENTE Y A COPIAS DE LOS DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene derecho a revisar su archivo de caso. Si llama o nos escribe, le proporcionaremos copias gratuitas de los documentos de su archivo que nosotros le proporcionaremos al oficial de audencia durante la audiencia justa. También, si usted llama o nos escribe, le proporcionaremos copias gratuitas de otros documentos de su archivo que pensemos que usted puede necesitar para prepararse para su audiencia justa. Para solicitar documentos o para determinar cómo revisar su archivo, llámenos al número de teléfono de la Sección de Acceso a Archivos (Record Access, en inglés) que se encuentra en la parte superior del frente de este aviso o escríbanos a la dirección impresa en la parte superior del frente de este aviso.

Si usted desea obtener copias de los documentos de su archivo de caso, debe solicitarlas por anticipado. Se le proporcionarán en un tiempo razonable antes de la fecha de la audiencia. Los documentos se le enviarán por correo únicamente si usted específicamente solicita que se le envíen por correo.

INFORMACIÓN: Si usted desea información adicional acerca de su caso, cómo solicitar una audiencia justa, cómo revisar su archivo o cómo obtener copias adicionales de documentos, por favor llámenos a los números de teléfono que se mencionan en la parte superior del frente de este aviso o escríbanos a la dirección impresa en la parte superior del frente de este aviso.

ATTACHMENT VI

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION

MEDICAID/FAMILY HEALTH PLUS DENIAL/FAMILY PLANNING BENEFIT PROGRAM DECLINATION

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.

We have denied your application for Medical Assistance/Family Health Plus dated _____ for:

(Name)_____ Client I.D. #_____
(Name)_____ Client I.D. #_____
(Name)_____ Client I.D. #_____

This is because your gross income of $_____ is over the Family Health Plus income limit of $_____ and your net income (gross income less Medical Assistance deductions) of $_____ is over the Medical Assistance income limit of :

- ❑ $_____for individuals 19 and above
- ❑ $_____for children age 1 through 18
- ❑ $_____for children under age 1

Please look at the budget calculation section to see how we figured your income.

The amount over the Medical Assistance limit is called excess income or spenddown. Your monthly excess income amount is $_____. You do not have paid or unpaid medical expenses not covered by insurance that are equal to or more than your excess income amount.

If you incur medical bills in the amount of your Medical Assistance excess income limit in the future, you may reapply.

Please read the Sections: "Explanation of the Excess Income Program" and “Optional Pay-In Program".

You were found eligible for the Family Planning Benefit Program, because your net income (gross income less Medical Assistance deductions) is at or below $_____ (200% of the Federal Poverty Level), which is the Medical Assistance income limit for these services. You have not been enrolled in the Family Planning Benefit Program, as you have chosen not to participate.

Children up to age 19 may be eligible for Child Health Plus B. Call 1-800-698-4543 for information.

Please be advised that you may reapply at any time in the future.

This decision is based on Sections 369-ee and 366 (1)(a)(11) of the Social Services Law and 18 NYCRR 360-4.8.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, 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

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

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

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 Hearing, 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_____

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 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 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 on 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.

ANEXO VI

AVISO DE RESOLUCIÓN SOBRE SU SOLICITUD DE ASISTENCIA MÉDICA

DENEGACIÓN DE MEDICAID/FAMILY HEALTH PLUS / RECHAZO DEL PROGRAMA DE BENEFICIOS PARA LA PLANIFICACIÓN FAMILIAR

FECHA DEL AVISO:		NOMBRE Y DIRECCION DE LA AGENCIA/CENTRO U OFICINA DE DISTRITO
NUMERO DE CASO	NUMERO CIN	
NOMBRE DEL CASO (Y Nombre del C/O Si Esta Presente) Y DIRECCION		
		NO. DE TELEFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA _____ - **O** para Conferencia con la Agencia _____ informacion y asistencia Sobre Vista Imparcial _____ Acceso a Archivos/Records _____ informacion sobre Asistencia Legal _____

OFICINA NO.	UNIDAD NO.	NO. del Trabajador(a)	NOMBRE DEL TRABAJADOR(A) O DE LA UNIDAD	NO. DE TELEFONO

Hemos denegado su solicitud para Asistencia Médica/Family Health Plus fechada el _____ para:
(Nombre)_____ # I.D. Paciente _____
(Nombre)_____ # I.D. Paciente _____
(Nombre)_____ # I.D. Paciente _____

Esto se debe a que su ingreso bruto de $_____ está por encima del límite de ingresos de Family Health Plus de $_____ y sus ingresos netos (ingreso bruto menos las deducciones por Asistencia Médica) de $_____ están por encima del límite de ingresos de Asistencia Médica de

- ❑ $_____ para personas de 19 años o mayores.
- ❑ $_____para menores entre 1 y 18 años de edad.
- ❑ $_____para niños menores de 1 año de edad.

Por favor consulte la sección de cálculo de presupuestos para ver cómo estimamos sus ingresos.

La cantidad por encima del límite de Asistencia Médica se llama excedente de ingresos o responsabilidad económica del paciente. El monto de su excedente de ingresos mensual es de $_____. Usted no tiene gastos médicos pagos o impagos, no cubiertos por el seguro, iguales o superiores al monto de su excedente de ingresos.

Si, en el futuro, usted incurre en gastos médicos equivalentes al monto de su límite de excedente de ingresos de Asistencia Médica, entonces podrá volver a solicitor la misma.

Por favor, lea las secciones: "Explicación del Programa de Excedente de Ingresos" y “Programa de Pagos Opcional".

Usted resultó elegible para el Programa de Beneficios para la Planificación Familiar porque sus ingresos netos (ingreso bruto menos las deducciones por Asistencia Médica) son iguales o inferiores a $_____ (200% del Índice Federal de Pobreza), que constituye el límite de ingresos de Asistencia Médica para estos servicios. Usted no ha sido inscripto en el Programa de Beneficios para la Planificación Familiar porque usted eligió no participar.

Los menores de hasta 19 años de edad, pueden calificar para Child Health Plus B. Llame al 1-800-698-4543 para solicitar información.

Por favor, tenga en cuenta que podrá voler a solicitarlo en cualquier momento, en el futuro.

Esta decisión fue tomada basándose en las Secciones 369-ee y 366 (1)(a)(11) de la Ley de Servicios Sociales y en 18 NYCRR 360-4.8.

LAS NORMAS EXIGEN QUE USTED NOTIFIQUE A ESTE DEPARTAMENTO DE INMEDIATO SOBRE CUALQUIER CAMBIO EN SUS NECESIDADES, RECURSOS, ORGANIZACIÓN DE VIDA O DIRECCIÓN

USTED TIENE DERECHO A APELAR ESTA DECISIÓN
ASEGÚRESE DE LEER EL DORSO DE ESTE AVISO RESPECTO DE CÓMO APELAR ESTA DECISIÓN

DERECHO A UNA CONFERENCIA: Usted puede tener una conferencia para revisar estas acciones. Si usted desea una conferencia, debe solicitar una tan pronto como sea posible. En la conferencia, si descubrimos que tomamos la decisión equivocada o si, debido a información que usted proporcione decidimos cambiar nuestra decisión, tomaremos acción correctiva y le proporcionaremos un nuevo aviso. Usted puede solicitar una conferencia llamándonos al número que aparece en la primera página de este aviso o enviándonos una petición por escrito a la dirección que se menciona en la parte superior de la portada de este aviso. Este número se utiliza sólo para solicitar una conferencia. ***No es la manera de solicitar una audiencia justa (fair hearing, en inglés).*** Si solicita una conferencia usted aún tiene derecho a una audiencia justa. Lea más adelante acerca de la información de audiencia justa.

DERECHO A UNA AUDIENCIA JUSTA: Si usted piensa que la acción anterior está equivocada, usted puede solicitar una audiencia justa Estatal:

(1) Llamando por teléfono: (POR FAVOR TENGA A LA MANO ESTE AVISO CUANDO LLAME)

Si vive en: La Ciudad de Nueva York (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

Si vive en: Los Condados de Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans o Wyoming: (716) 852-4868

Si vive en: Los Condados de Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne o Yates: (716) 266-4868

Si vive en: Los Condados de Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins o Tioga: (315) 422-4868

Si vive en: Los Condados de Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington o Westchester: (518) 474-8781

Si vive en: Los Condados de Nassau o Suffolk: (516) 739-4868

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(2) **Escribiendo:** Enviando una copia de este aviso **debidamente llenado**, a la Oficina de Audiencias Administrativas de la Oficina de Asistencia Temporal y de Discapacidades del Estado de Nueva York a la siguiente dirección: Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Por favor conserve una copia para usted.

Deseo una audiencia justa. La acción de la Agencia está equivocada debido a:

_____

_____

_____

Firma del Cliente: _____ Fecha: _____

USTED TIENE 60 DÍAS DESPUÉS DE LA FECHA DE ESTE AVISO PARA SOLICITAR UNA AUDIENCIA JUSTA

Si usted solicita una audiencia justa, el Estado le enviará un aviso informándole de la hora y el lugar de la audiencia. Usted tiene derecho a que un asesor jurídico, un familiar, un(a) amigo(a) u otra persona lo(a) represente o a representarse a sí mismo(a). Durante la audiencia usted, su abogado u otro representante tendrán la oportunidad de presentar evidencia por escrito y verbal para demostrar por qué no se debe tomar la acción, así como también la oportunidad de cuestionar a cualquier persona que comparezca durante la audiencia. También tiene derecho a presentar testigos para que hablen en su favor. Usted debe traer a la audiencia cualquier documento, como por ejemplo, este aviso, talones de sueldo, recibos, facturas médicas, facturas de calefacción, verificación médica, cartas, etc. que puedan ser útiles para presentar su caso.

ASISTENCIA LEGAL: Si necesita asistencia legal gratuita, es posible que usted pueda obtener dicha asistencia comunicándose con la Sociedad de Asistencia Legal local u otro grupo defensor legal. Usted puede localizar a la Sociedad de Asistencia Legal (Legal Aid Society, en inglés) o grupo defensor más cercano revisando las Páginas Amarillas de su directorio telefónico bajo el título “Lawyers” (que significa “Abogados”) o llamando al número que se indica al frente de este aviso.

ACCESO A SU EXPEDIENTE Y A COPIAS DE LOS DOCUMENTOS: Para ayudarle a prepararse para la audiencia, usted tiene derecho a revisar su archivo de caso. Si llama o nos escribe, le proporcionaremos copias gratuitas de los documentos de su archivo que nosotros le proporcionaremos al oficial de audencia durante la audiencia justa. También, si usted llama o nos escribe, le proporcionaremos copias gratuitas de otros documentos de su archivo que pensemos que usted puede necesitar para prepararse para su audiencia justa. Para solicitar documentos o para determinar cómo revisar su archivo, llámenos al número de teléfono de la Sección de Acceso a Archivos (Record Access, en inglés) que se encuentra en la parte superior del frente de este aviso o escríbanos a la dirección impresa en la parte superior del frente de este aviso.

Si usted desea obtener copias de los documentos de su archivo de caso, debe solicitarlas por anticipado. Se le proporcionarán en un tiempo razonable antes de la fecha de la audiencia. Los documentos se le enviarán por correo únicamente si usted específicamente solicita que se le envíen por correo.

INFORMACIÓN: Si usted desea información adicional acerca de su caso, cómo solicitar una audiencia justa, cómo revisar su archivo o cómo obtener copias adicionales de documentos, por favor llámenos a los números de teléfono que se mencionan en la parte superior del frente de este aviso o escríbanos a la dirección impresa en la parte superior del frente de este aviso.