

**CNS Paragraph Form**

Date: 09.02.08

<b>Program Area</b>	<b>03</b>	<b>(01=PA, 02=FS, 03=MA, 04=HP)</b>
<b>Paragraph Number</b>	<b>U0072</b>	
<b>Version Number</b>	<b>00003</b>	
<b>Effective Date</b>	<b>2009</b>	
<b>Title</b>	<b>Community Coverage without LTC to All Covered Care and Services, FP</b>	
<b>Comment</b>		
<b>Reason Code</b>	<b>C60</b>	

We will increase your Medicaid coverage from Community Coverage without Long-Term Care to All Covered Care and Services effective \_\_\_\_\_.

Name	Client I.D.#
Name	Client I.D.#
Name	Client I.D.#

This is because you requested an increase in your Medicaid coverage and gave us proof of your current income and proof of your resources for the transfer of assets look-back period.

This decision is based on Regulations 18 NYCRR 360-2.2, 360-2.3 and Sections 366-a(2) and 366-a(5)(d) and (e) of Social Services Law.

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Incrementaremos su cobertura de Medicaid de cobertura comunitaria sin atencion medica a largo plazo, a cobertura total de cuidados y servicios, a partir de \_\_\_\_\_.

Nombre	# de ID del cliente:
Nombre	# de ID del cliente:
Nombre	# de ID del cliente:

Esto se debe a que usted solicito un incremento en su cobertura de Medicaid y nos dio comprobante de su ingreso actual y comprobante de recursos relativo al traspaso de bienes de un periodo retroactivo.

Esta decision se basa en Reglamentacion 18 NYCRR 360-2.2, 360-2.3 y las Secciones 366-a(2) y 366-a(5)(d) y (e) de la Ley de Servicios Sociales.