NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management

# NOTICE OF INTENT TO DISCONTINUE/CHANGE MEDICAID COVERAGE (Transfer of Assets)

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

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

This is to advise you that this Department intends to change your Medicaid coverage as indicated below.

We have determined that on (date) ______________ you/your spouse transferred (item(s)) ____________________________________ ____________________________ valued at $ __________. This amount is considered to be the **uncompensated value**.

Because you/your spouse transferred this asset(s) for less than it was worth, you are **not** eligible for the following types of care and services:

- services provided in skilled nursing facilities, health-related facilities, intermediate care facilities, or residential treatment facilities.
- nursing facility services provided in a hospital.
- home and community based services provided pursuant to Section 1915 (c) or (d) of the Social Security Act.

Based on your current circumstances we are taking the following action:

☐ **REDUCE** your Medicaid coverage from coverage for all care and services under the Medicaid Program to limited coverage effective (date) ____________________. You are not eligible to receive the services listed above. However, you are eligible to receive all other care and services provided under the Medicaid Program effective (date) ____________. You will have to meet an excess income requirement for these services if there is an ☒ in Excess Income Box below.

☐ **DISCONTINUE** your Medicaid coverage effective (date) ________________. Based on your current circumstances you are **not** eligible for the above noted care and services for a period of __________ month(s) or until (date) ______________. This is based on the following calculations:

| | | |
|---|---|---|
| Uncompensated valued of transferred asset(s) (less Medicaid exemption, if applicable) | | $ ____________ |
| | ÷ | |
| Monthly regional rate | | $ ____________ |
| Period of limited coverage: | | ____________ (month(s)) |

☐ You will also have an additional $ _____________ that you will have to contribute toward your cost of care for the month of ________________________. This is in addition to any income contribution that must be contributed toward your cost of care for that month.

Although you are not eligible for certain types of care and services because of the above-referenced transfer, you may be eligible for coverage of other care and services not included in the facility's rate, *(e.g., eyeglasses, hearing acids, dentures and acute hospital care)*. In order for you to be eligible for this coverage, either: (1) your income must be no greater than the allowable Medicaid income standards; or (2) if your income exceeds the allowable Medicaid income standards, you must meet certain excess income requirements. You will have to meet an excess income requirement for these services if there is an ☒ in the box below.

☐ **INCREASE** your Medicaid coverage from limited coverage to coverage for all care and services effective (date) ______________. The reason for this change is because the penalty period due to your transfer of asset(s) for less than fair market value will expire on (date) _______________. Effective this date you are entitled to all care and services provided under the Medicaid Program. You will have to meet an excess income requirement for these services if there is an ☒ in the box below.

☐ **EXCESS INCOME** your total gross monthly income is $ _________. Your total monthly deductions are $ ___________. The difference between these is your net monthly income. This is $ __________. The allowable income standard for a family household your size is $ ____________. The difference between your monthly income and this standard ($ ____________) is the monthly spenddown or excess income amount. Your excess income for six months is $ ____________. Please see the enclosed Form OHIP-0026, which explains how you can meet the excess income requirements and become eligible for coverage under the EXCESS INCOME PROGRAM.

**NOTE:** If there are other factors which affect your Medicaid coverage, a separate notice is enclosed.

READ THE ENCLOSED NOTICE (Effect of Transfer of Asset(s) on Medicaid Eligibility) FOR IMPORTANT INFORMATION CONCERNING TRANSFER OF ASSETS.

This decision is based on Regulations 18 NYCRR 360-4.4, 360-4.5, 360-4.7 and 360-4.8 and Section 366.5 of the Social Services Law.

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

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**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 the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing***. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. Read below for fair hearing information.

**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. If you call or write to us, we will also make available to you without charge specific policy materials necessary for you to decide whether to request a fair hearing or to prepare for the hearing. Policy materials that may be available to you include documents such as: Administrative Directives, General Information System messages, Informational Letters, portions of the Medicaid Reference Guide, Department of Health Medicaid Update newsletters and Local Commissioner Memorandums. To ask for specific policy materials, documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice. If you want free copies of specific policy materials or 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.

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

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**
2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**
3) **On-Line:** Complete and send the online request form at: **http://www.otda.ny.gov/oah/forms.asp.; OR**
4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

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

______________________________________________________________________

Print Name: ______________________________ Case Number______________________

Address: ______________________________________Telephone: ___________________

Signature of Client: __________________________________ Date: ___________________

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING:** If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

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

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

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

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

**ATTENTION:** Children under 19 years of age who are not eligible for Medicaid or other health insurance may be eligible for the Child Health Plus Insurance Plan for kids. The plan provides health care insurance for children. Call 1-800-698-4543 for information.