NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

NOTICE OF ACTION ON APPLICATION/BENEFIT FOR MEDICAID PAYMENT OF THE COBRA CONTINUATION COVERAGE PREMIUM

NOTICE 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 Department has made a decision concerning the eligibility for Medicaid payment of your COBRA continuation coverage premiums.

This Department will:

☐ **ACCEPT** the application dated _____ for (name(s)) _____

_____ from _____ to _____.

You are responsible for premium bills incurred before the effective date. Keep this letter for your use.

☐ We have accepted your application to have the Medicaid program pay for your group health insurance premiums under the COBRA Continuation Coverage Program for (name(s)) _____ **pending documentation of your eligibility.** We will send you a decision about your application once we verify your eligibility. In the meantime, we will pay your health insurance premiums beginning (date) _____. You are responsible for premium bills incurred before the begin date. If we find you are not eligible, you will also be responsible for all premiums we paid for you.

☐ **DENY** the application dated _____, for (name(s)) _____

_____. ☐ You are responsible for payment of your premiums.

☐ We will pay the premium on behalf of (name(s)) _____

_____, from _____ to _____.

☐ **TAKE NO ACTION** on the application dated _____ since it was withdrawn.

☐ **CONTINUE** the benefits under the COBRA Continuation Coverage Program for (name(s)) _____

_____

from _____ to _____.

☐ **DISCONTINUE** the benefits under the COBRA Continuation Coverage Program for (name(s)) _____

_____

effective _____.

☐ **DISCONTINUE** the benefits under the COBRA Continuation Coverage Program which we had accepted pending documentation of eligibility effective _____.

The reason for this action is as follows: _____

_____.

If this application is being denied or discontinued for financial reasons, we have enclosed a budget worksheet(s) so that you can see how we determined eligibility for the Medicaid payment of the COBRA Continuation Coverage premium.

This decision is based on Regulation 18 NYCRR 360-7.5(h) and Section 367-a(1)(d) 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.

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.