

**NOTICE OF DECISION ON YOUR MEDICAID APPLICATION**

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									
<div style="border: 1px solid black; width: 100%; height: 100%; position: relative;"> <span style="position: absolute; top: 5px; left: 5px;">┌</span> <span style="position: absolute; top: 5px; right: 5px;">┐</span> <span style="position: absolute; bottom: 5px; left: 5px;">└</span> <span style="position: absolute; bottom: 5px; right: 5px;">┘</span> </div>				GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____					
				<b>OR</b> 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 eligibility under the Medicaid Program. We are sending this notice to tell you that this Department will:

- ACCEPT the Medicaid application dated \_\_\_\_\_, with coverage as follows:
- All covered care and services effective \_\_\_\_\_, for name(s) \_\_\_\_\_.
- Please review the Medical Assistance Utilization Threshold Fact Sheet, found in the Medical Assistance section of the booklet, "LDSS-4148B: What You Should Know About Social Services Programs". The Fact Sheet explains any services limitations. The LDSS-4148B was given to you when you applied for assistance.
- The applicant(s) may be eligible for direct reimbursement of medical expenses paid on or after \_\_\_\_\_. We will notify you of our decision.
- DENY the Medicaid application dated \_\_\_\_\_ for the (name(s)) \_\_\_\_\_ because:
- The applicant(s) has EXCESS RESOURCES in the amount of \$ \_\_\_\_\_. The enclosed information explains how individuals may become eligible under the EXCESS RESOURCE PROGRAM. The determination of excess resources includes information received through computer matches with banking institutions. If you think the excess resource amount is incorrect, you must contact the agency immediately, but no later than 30 days from the date of this notice.
  - The applicant(s) has EXCESS INCOME in the amount of \$ \_\_\_\_\_ month. The enclosed information explains how individuals may become eligible under the EXCESS INCOME PROGRAM/OPTIONAL PAY-IN PROGRAM.

**IN SOME CIRCUMSTANCES, THE MEDICAID PROGRAM DOES NOT COUNT INCOME THAT IS PLACED IN A SUPPLEMENTAL NEEDS TRUST. PLEASE READ THE ENCLOSED "EXPLANATION OF THE EFFECT OF TRUSTS ON MEDICAID ELIGIBILITY". THIS INFORMATION IS ALSO AVAILABLE ON THE DEPARTMENT OF HEALTH WEBSITE AT: [https://health.ny.gov/health\\_care/medicaid/index.htm#trusts](https://health.ny.gov/health_care/medicaid/index.htm#trusts).**

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- TAKE NO ACTION on the Medicaid application dated \_\_\_\_\_ for (name(s)) \_\_\_\_\_ because it was withdrawn.

The LAW AND/OR REGULATION(S) which allow us to do this are \_\_\_\_\_.

We have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

*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.