

NOTICE OF INTENT TO ESTABLISH A LIABILITY TOWARD CHRONIC CARE

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 _____ <hr/> 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 eligibility under the Medicaid Program of the individual named above, who has been determined to be residing in a medical institution on a permanent basis. (If the individual was previously in receipt of full Medicaid coverage or Medicaid coverage subject to a spenddown amount of \$ _____, the required contribution towards institutional costs is explained below.)

Date of Application: _____
 Date of Institutionalization: _____
 Date of Chronic Care Status: _____

We have calculated the total **monthly** contribution toward the cost of this individual's care for the period indicated, as follows:

INCOME

From _____ To _____	From _____ To _____
Gross Monthly Income \$ _____	Gross Monthly Income \$ _____
Deductions - _____	Deductions - _____
Income Allowance (Medical Assistance Level) - _____	Income Allowance (Personal Needs Level) - _____
Contribution to Community Spouse - _____	Contribution to Community Spouse - _____
Family Member Allowance(s), or Dependent Household Member(s) - _____	Family Member Allowance(s), or Dependent Household Member(s) - _____
Cost of Medical/Remedial Care - _____	Cost of Medical/Remedial Care - _____
Remaining Available Monthly Income = _____	Remaining Available Monthly Income = _____
Contribution from Spouse + _____	Contribution from Spouse + _____
Total Income Contribution Per. Mo. \$ _____	Total Income Contribution Per. Mo. \$ _____
Payable to: _____	Payable to: _____

NOTE: Your monthly income contribution is based on a projection of income expected to be received. Adjustments will be made if your income or circumstances change.

RESOURCES

Resources, if any, must also be considered in calculating your eligibility.

Countable Resources	\$ _____
Medicaid Resource Limit	- _____
Excess Resources	= _____
Medical Bills Used to Reduce Excess Resources	- _____
Remaining Excess Resources	\$ _____

In addition to any income contribution(s) the remaining \$ _____ of excess resources must be contributed toward the cost of care during the month of _____. 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 Medicaid Program will pay any additional covered institutionalized costs during the authorized period.

This decision is based on Regulations 18 NYCRR 360-4.9, 360-4.3(f) and 360-4.10 and Section 366 of the Social Services Law.

The enclosed budget worksheet(s) explains these calculations.

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**

Enclosure
 cc:

 NAME OF MEDICAL FACILITY

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.