NEW YORK STATE DEPARTMENT OF HEALTH
Home and Community Based Services (HCBS)

Notice of Decision
For Discontinuance in the New York State 1915(c) Children's Waiver

Notice Date	Effective Date	CIN Number

Member (child/youth)	Name
	Date of Birth
c/o Parent/Guardian/Legally Authorized Representative, if any	Name
Health Home	Name
	Address
	Telephone Number

This is to advise you that effective _____ this agency _____
Date Name of Health Home

☐ **Discontinued your HCBS enrollment in the 1915(c) Children's Waiver**

Your enrollment in the waiver and access to HCBS are being discontinued as of the effective date above due to the following reason(s):

- ☐ You no longer meet the Level of Care criteria of Target, Risk and Functional requirements necessary for enrollment in the waiver
- ☐ You have turned 21
- ☐ You receive HCBS services from another HCBS system (e.g. OPWDD or MLTC)
- ☐ You have received inpatient care for greater than 90 days (e.g. Residential Treatment Facility, Nursing Home, Hospital etc.)
- ☐ You are currently incarcerated
- ☐ Other _____

This action is taken under HCBS Children's Waiver Authority NY 4125 R05.02 and 42 CFR 441.302(c) and Social Services Law 366(6), 366(7), 366(9), or 366(12)

Signature of Health Home Representative	X

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

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.

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.
5) **Walk In:** New York City:
   Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   14 Boerum Place – 1st Floor
   Brooklyn, New York 11201
6) **Speech and Hearing Impaired**
   Contact the New York Relay Service at 711 or 1-800-622-1220. Request that the operator call 877-502-6155. Service at this number will only be provided to callers using TDD equipment.

☐ I want a Fair Hearing. The Agency's action is wrong because _____

_____

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, paystubs, receipts, health care bills, heating bills, medical verification, doctor's 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.

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.

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 2 of this notice or write to us at the address printed at the top of page 2 of this notice.

Print Name:	Client Identification Number (CIN):
Address:	Telephone Number:

Signature: X	Date: