NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

NOTICE OF DECISION ON YOUR MEDICAID APPLICATION FOR RETROACTIVE COVERAGE

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.

As of _____ your health care coverage is authorized through the New York State of Health. We have made a decision concerning your request for coverage for medical bills in the three month period prior to your application to the New York State of Health. We are sending this notice to tell you that this Department will:

☐ ACCEPT the Medicaid application dated _____, with coverage for the period _____ to _____ as follows:

☐ All covered care and services for (name(s))_____
_____

☐ With a SPENDDOWN requirement for (name(s)) _____
_____.

This is because your net income (gross income less Medicaid deductions) of $_____ is over the allowable Medicaid income limit of $_____. The amount over the limit is called excess income or spenddown. Your monthly excess income amount is $_____.

☐ Outpatient Medical Care Only - You have verified paid or unpaid medical expenses which equal $_____, the excess income for the month(s) of _____. The Medicaid Program will pay those covered outpatient expenses which exceed the monthly spenddown for the month(s) noted.

☐ Outpatient Medical Care and Inpatient Hospital Medical Care (all covered care and services) - You have verified paid or unpaid medical expenses which equal $ _____ (the excess income for the six month period from _____ to _____). The Medicaid Program will pay any additional covered medical expenses incurred during this period.

Please read the enclosed "Explanation of the Excess Income Program."

If you submitted paid medical bills for direct reimbursement, you will be notified separately of our decision.

☐ DENY the Medicaid application dated _____ for (name(s))_____
_____because:

☐ You are not eligible for Medicaid because your net income (gross income less Medicaid deductions) of $_____ is over the allowable Medicaid income limit of $_____. The amount over the limit is called excess income or spenddown. Your monthly excess income amount is $_____. We have not received documentation that you have paid or unpaid medical expenses not covered by insurance that are equal to or more than your excess income.

☐ Other: _____
_____
_____
_____

This decision is based on Social Services Law section 364-i(7).

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 front 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. 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.

☐ 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 front 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. To ask for 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 copies of 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 the front of this notice or write to us at the address printed at the top of the front 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.