NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID 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.

New York State of Health Account Holder's Name _____
Application Date_____

Enclosed is the application required to determine Medicaid eligibility for the following individuals:

Name _____
Name _____
Name _____

This application is being sent to you for one of the following reasons:

- the New York State of Health (Marketplace) determined that your Modified Adjusted Gross Income was over the allowable income level;
- due to your age (65 years or older) or receipt of Medicare benefits, the Marketplace could not determine your eligibility; or
- you requested coverage for medical bills in the three month period prior to you application.

However, your Medicaid eligibility can be determined on a different basis that takes into account both your income and certain deductions that were not applied by the Marketplace. If your income is still over the allowable Medicaid income level after this determination, you may be eligible to participate in the Excess Income Program. This eligibility can only be determined by your Local Department of Social Services.

To have us determine your eligibility, you will need to complete and sign the application included with this letter and provide required documentation. The "Documentation Checklist" in the application lists the types of proof. We will use the application date noted at the top of this letter.

If you are blind, disabled, or age 65 or over, you also need to complete the enclosed Access NY Supplement A form.

You may call your Local Department of Social Services for help with this application. You must return the application and documentation to the address listed above by _____. You may wish to keep a copy of this application for your records.

If we do not receive the requested information, we will not be able to determine your Medicaid eligibility and your application will be denied.

MAKE SURE YOU ANSWER EVERY QUESTION AND SIGN THE APPLICATION. RETURN ALL PAGES AND THE DOCUMENTATION BY MAIL OR IN PERSON TO YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES OFFICE. YOU DO NOT NEED TO COME IN FOR AN INTERVIEW.