

**NOTICE OF ACTION ON APPLICATION/BENEFIT FOR MEDICAL ASSISTANCE PAYMENT OF THE
MEDICARE PART A PREMIUM**

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.

This Department has made a decision concerning your eligibility for Medical Assistance payment of your Medicare Part A premium.

This Department will:

- ACCEPT the application dated _____ for (name)_____.
Medical Assistance will pay your monthly Medicare Part A premium effective_____.
If you are currently paying the Medicare Part A premium, you will continue to be responsible for paying the premium bills for the months before the effective date.
- DENY the application dated_____ for (name)_____.
If you are currently paying Medicare Part A premiums and you no longer want Medicare Premium Part A coverage, you should notify your local social security administration office immediately to stop Part A coverage.
- DISCONTINUE payment of Medicare Part A premiums for (name)_____, effective_____. If you are not eligible for premium free Medicare Part A and you do not want to pay for Medicare Part A coverage, you should notify your local social security administration office immediately, to stop your Medicare Part A coverage.

The reason for this action is as follows;

- You are not eligible for Medical Assistance to pay your Medicare Part A premium because your net income (gross income less Medical Assistance deductions) of \$_____ Is over the income limit of \$_____for Medical Assistance to pay your Part A premium.
- You are not eligible for Medical Assistance to pay your Medicare Part A premium because your countable resources of \$_____ are over the resource limit of \$_____ for Medical Assistance to pay your Part A premium.
- You are not eligible for Medical Assistance to pay your Medicare Part A premium because_____.

This decision is based on Regulations 18 NYCRR 360-7.8(a) and 360-7.7(g).

*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 a 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. 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) **Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 417-6550

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (585) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, or Westchester County: (518) 474-8781

If you live in: Nassau or Suffolk County: (516) 739-4868

OR

(2) **Writing:** By sending a copy of this notice **completed**, to the Office of Administrative Hearing, 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:

Name: _____ Case Number _____

Address _____

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.

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 that 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 that 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 the Record Access telephone number listed at the top of page 1 of this notice, or write us at the address printed at the top of page 1 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 on 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.