STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 30, 2007
CASE #: **********
CENTER #: MAP
FH #: 4838853P

In the Matter of the Appeal of

****

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on October 17, 2007, in **********, before Mark M. Reid, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

**********, Appellant

For the Social Services Agency

Debra Gaskins, Fair Hearing Representative; Nadine Lopez-Flores, Fair Hearing Supervisor

ISSUE

Was the Agency's June 11, 2007 determination to reduce the Appellant's Medical Assistance authorization by a "Notice of Acceptance of Your Medical Assistance Application" correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant and the Appellant's children ages 20 and 17 years old were in receipt of Medical Assistance on a Public Assistance case, and subject to no spenddown of monthly excess income. The Appellant's 20 and 17 year old children are in receipt of Medical Assistance and the Medical Assistance eligibility of the Appellant's children was not an issue at the hearing.

The discontinuance of the Appellant's Public Assistance case was the subject of fair hearing #4870121K, and was not an issue at the present hearing.

2. By Notice dated June 11, 2007, the Agency informed the Appellant, by a notice titled "Notice of Acceptance of Your Medical Assistance Application", of its determination to reduce the Appellant's Medical Assistance for the Appellant. The Agency's Notice informs the Appellant that she will be eligible for Medical Assistance only subject to a spenddown of monthly excess income. The Agency determined that the Appellant's household's monthly excess income for the purposes of computing Medical Assistance eligibility is $131.00. The Agency's June 11, 2007 Notice does not contain information about the action the Agency proposes to take or is taking, did not state that it was a reduction of existing Medical Assistance coverage, did not state the prior amount of the Appellant's excess income, and did not set forth a proposed date of reduction of ten days subsequent to the date of the Notice.

3. The Agency's June 11, 2007 Notice did not include a determination of the Appellant's eligibility for Family Health Plus benefits.

4. On July 30, 2007, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 358-3.3(a) of the Regulations provides, in pertinent part, that a recipient has a right to timely and adequate notice when a social services agency:

> proposes to take any action to ... reduce a Medical Assistance Authorization...

Section 358-2.2 of the Regulations provides, in pertinent part:

> An adequate notice means a notice of action, or an adverse action notice or an action taken notice which sets forth all of the following:
>
> the action the social services agency proposes to take or is taking... In addition, in the case of:
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> ***
>
> an increase in the amount of a medical assistance spenddown: the amount of the spenddown, if any, prior to the increase and the spenddown amount after the increase must be specified. In addition, such notice must include an explanation of the procedures to be followed for meeting the spenddown;
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> ***
>
> when the agency action or proposed action is a reduction ... of medical assistance ... the circumstances under which medical assistance ... will be continued or reinstated until the fair hearing decision is issued...

Section 358-2.23 of the Regulations provides:

> Timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective.

A person who is sixty-five years of age or older, blind or disabled who is not in receipt of Public Assistance and has income or resources which exceed the standards of the Federal Supplemental Security Income Program (SSI) but who otherwise is eligible for SSI may be eligible for Medical Assistance, provided that such person meets certain financial and other eligibility requirements under the Medical Assistance Program. Social Services Law Section 366.1(a)(5).

To determine eligibility, an applicant's or recipient's net income must be calculated. In addition, resources are compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The result - net income - is compared to the statutory "standard of need" set forth in Social Services Law Section 366.2(a)(7) and 18 NYCRR Subpart 360-4. If an applicant's or recipient's net income is less than or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable standard, full Medical Assistance coverage is available.

Regulations at 18 NYCRR 360-4.6 provide for additional income disregards for applicants and recipients who are 65 years of age or older, certified blind or certified disabled. These disregards are to be applied in the following order:

- all reparations payments received from the Federal Republic or Germany;
- the first $20 per month of any unearned income. Only one $20 disregard is permitted per couple. A certified blind or certified disabled child living with parents is entitled to a separate $20 disregard from his/her total unearned income. If a person's unearned income is under $20, the balance will be deducted from earned income;
- the first $65 of earned income;
- for disabled MA applicants/recipients, non-medical, impairment-related work expenses;
- one-half of the remaining earned income after the disregards listed in 1-5 above have been applied;
- health insurance premiums;

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The amount by which net income exceeds the standard of need is considered "excess income". If the applicant or recipient has any excess income, he/she must incur bills for medical care and services equal to or greater than that excess income to become eligible for Medical

Assistance. In such instances Medical Assistance coverage may be available for the medical costs which are greater than the excess income. If a person has expenses for in-patient hospital care, the excess income for a period of six months shall be considered available for payment. For other medical care and services the excess income for the month or months in which care or services are given shall be considered available for payment of such care and services. 18 NYCRR 360-4.1, 360-4.8.

Administrative Directive 87 ADM-4 provides detailed instructions regarding the appropriate application of medical bills to offset excess income so that an individual can become eligible for Medical Assistance. This offsetting process is called "spenddown". Said Directive further provides that whenever a spenddown is indicated, the Agency is required to include a copy of the letter "Explanation of the Excess Income Program" along with the Notice to the recipient whenever an acceptance, intended change, denial, or discontinuance indicates a spenddown liability situation. Administrative Directive 87 ADM-4 provides that some over-the-counter drugs and medical supplies such as bandages and dressings may be applied to offset determined excess income if they have been ordered by a doctor or are medically necessary. Bills for cosmetics and other non-medical items may not be so applied.

Administrative Directive 91 ADM-27 provides, in part:

2. Income

a. When a household consists of an SSI-related couple (neither of whom receives a PA grant or SSI cash), with or without children, the household size for the SSI-related couple is two.

b. When a household (with or without children), consists of an SSI-related spouse and a non-SSI-related spouse whose income is equal to or more than the allocation amount after allocating to any child(ren) under the age of 18 years, income is deemed and the household size is two for the SSI-related spouse. (The allocation amount is the difference between the MA level for two and the MA level for one).

If a non-SSI-related spouse's income is below the allocation amount after allocation to any child(ren) under the age of 18 years, the non-SSI-related spouse's income is not deemed to the SSI-related spouse, and that spouse is not counted in the MA income household size for the SSI-related spouse. In such instances, the SSI-related applicant's household size is one. However, to determine resource eligibility, a household of two is used. An example of such a case is detailed in Attachments E and F of this Directive.

c. For all other SSI-related adults or children, the household size is one.

3. Related Issues

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d. SSI-related A/Rs must be offered a choice between the SSI and ADC budgeting methodologies, if the A/Rs meet the categorical requirements for ADC. It may be more advantageous if there are children or a pregnant woman in the household to use the ADC methodology, which allows the income and resources to be compared to a larger household size.

82 ADM-6 requires agencies to explain the advantages and disadvantages of including a child with income in the Medical Assistance household. A child may be included even when the child's income is sufficient to meet the child's needs under Medical Assistance. The applicant has the right to decide whether to include or exclude the child or children. The applicant may choose to include in the household only those children for whom medical care is required. In addition, the applicant may choose to delete a child's needs and income from the Medical Assistance household at any time.

Section 366(1)(a) of the Social Services Law sets forth the conditions under which individuals and families may qualify for Medical Assistance Low-Income Families With Children (LIF) may qualify for Medical Assistance if they meet specific eligibility standards. Categorically, Low Income Families With Children include the following:

- Parents and/or other caretakers residing with children under 21 years of age, and all such children;

- Persons under 21 residing without a parent, including children in foster care but not eligible for payments under Title IV-E of the Social Security Act; and/or

- Pregnant women.

Low Income Families With Children may include those currently receiving Public Assistance, as well as those who, although not currently receiving Public Assistance, have insufficient income and resources to meet the costs of necessary medical care and services for the family, including those who could qualify for Public Assistance were they to apply.

LIF eligibility is to be determined using Family Assistance methodology found in Parts 351, 352 and 369 of the Regulations. Under this methodology, income is subject to (i) a gross income test, under which its gross income must be no greater than 185 percent of its Public Assistance standard of need; (ii) a federal poverty level test, under which its income must be no greater than 100 percent of the federal poverty level for a family of comparable size; and (iii) a net income test, under which net income, after deducting all authorized disregards, is no greater than the applicable Public Assistance standard of need. In addition, the family resources must not exceed certain levels. If the family income and resources meet all of those tests, the family may qualify for Medicaid with full coverage. No "spend-down" of income exceeding the applicable standard is permissible using LIF budgeting methodology.

For families that do not qualify for Medicaid under LIF budgeting, Medicaid may still be obtained under "ADC-related" medically needy budgeting methodology. Under this

methodology, the amount of the family's available net income will be determined using the exemptions and disregards applicable to the "ADC-related" medically needy budgeting methodology. All earnings must be offset by (i) $90 (per employed family member) for Work Related Expenses; (ii) in accordance with 97 OMM/ADM-2, the $30 and 1/3 earned income disregard when the family received Medicaid under LIF in at least one of the past four months; and (iii) Child Care Expenses as authorized in Section 360-4.6 of the Regulations. After adding the remaining earnings to all other countable income received by the family, the local district must then compare the total net income to the higher of EITHER:

(a) the Public Assistance Standard of Need (the same as that required for Family Assistance); OR

(b) the Medicaid Income Exemption Standard.

Pregnant women and certain children may qualify for full coverage of their own medical needs if family income does not exceed the following "Expanded Eligibility" limits set forth in Section 360-4.7 of the Regulations:

- pregnant women and infants younger than one year of age, if available family income does not exceed 200 percent of the Federal Poverty Line ("FPL") (Social Services Law 366.4(n) and o);

- children, from age one up to their sixth birthday, if available family income does not exceed 133 percent of the FPL; (Social Services Law 366.4(p);

- children, between six and nineteen BUT only if born after September 30, 1983, if available family income does not exceed 100 percent of the FPL. (Social Services Law Section 366(4)(q)(1));

Effective January 1, 1999, Section 366(4)(s) of the Social Services Law provides that children determined eligible under low income family (LIF) budgeting or using federal poverty levels are to be provided 12 continuous months of Medicaid coverage regardless of any changes in income or circumstances. An interpretation of this law in 99 OMM/ADM-3, provides that effective August 30, 1999, continuous coverage applies also to children whose eligibility was determined using the ADC-related budgeting methodology. Children are guaranteed 12 months of continuous coverage every time eligibility is determined or redetermined. Continuous coverage can run concurrently with an extension, such as Transitional Medical Assistance (TMA). If a child becomes ineligible for Medicaid, the child will receive the longest available period of additional coverage, whether provided by the extension or by continuous coverage. The expansion of continuous coverage by this provision of the Social Services Law does not apply to children whose eligibility is determined using the "standard" medically needy Medicaid income level.

Under Section 360-4.8(c) of the Regulations, Medicaid with a "spend-down" may be authorized for children when family income exceeds the higher of the Public Assistance standard

or the Medicaid Income Exemption standard. In addition, parents may also be eligible with a "spend-down" when their income exceeds such level when the children are deprived of parental support or care ("deprivation factor". Families subject to a "spend-down" may become eligible for coverage for outpatient care and services if it has medical bills in any month that are equal to or more than the amount of excess income. Such families may become eligible for outpatient and inpatient medical care and services if a family owes or has paid an amount for medical bills equal to the sum of its monthly excess income for six months.

Department Regulations at 18 NYCRR 360-7.5(a) set forth how the Medical Assistance Program will pay for medical care. Generally the Program will pay for covered services which are necessary in amount, duration and scope to providers who are enrolled in the Medical Assistance program, at the Medical Assistance rate or fee which is in effect at the time the services were provided.

In instances where an erroneous eligibility determination is reversed by a social services district discovering an error, a fair hearing decision or a court order or where the district did not determine eligibility within required time periods, and where the erroneous determination or delay caused the recipient or his/her representative to pay for medically necessary services which would otherwise have been paid for by the Medical Assistance Program, payment may be made directly to the recipient or the recipient's representative. Such payments are not limited to the Medical Assistance rate or fee but may be made to reimburse the recipient or his/her representative for reasonable out-of-pocket expenditures. The provider need not have been enrolled in the Medical Assistance program as long as such provider is legally qualified to provide the services and has not been excluded or otherwise sanctioned from the Medical Assistance Program. An out-of-pocket expenditure will be considered reasonable if it does not exceed 110 percent of the Medical Assistance payment rate for the service. If an out-of-pocket expenditure exceeds 110 percent, the social services district will determine whether the expenditure is reasonable. In making this determination, the district may consider the prevailing private pay rate in the community at the time services were rendered, and any special circumstances demonstrated by the recipient. 18 NYCRR 360-7.5(a).

Pursuant to section 369-ee of the Social Services Law, a person is eligible to receive health care services under the Family Health Plus Program if he or she:

(i) resides in New York state and is at least age nineteen, but under sixty-five years of age;

(ii) is not eligible for medical assistance solely due to income or resources or is eligible for medical assistance only through the application of excess income toward the costs of medical care and services;

(iii) does not have equivalent health care coverage under insurance or equivalent mechanisms;

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(v)(A) in the case of a parent or stepparent of a child under the age of twenty-one who lives with such child, has gross family income equal to or less than the applicable percent of the federal income official poverty:

(I) January 1, 2001 – 120% and

(II) October 1, 2001 – 133% and

(III) October 1, 2002 – 150%; or

(B) in the case of an individual who is not a parent or stepparent living with his or her child under the age of twenty-one, has gross family income equal to or less than 100% of the federal income official poverty line for a family of the same size.

In order to be eligible for Family Health Plus, 19 and 20-year-olds living with their parents, must have gross family income equal to or less than the following federal income poverty lines for a family of the same size:

- effective January 1, 2001, 120 percent; and
- effective October 1, 2001, 133 percent; and
- effective October 1, 2002, is 150 percent.

01 OMM/ADM-6

In order to be eligible for Family Health Plus, 19 and 20 year-olds not residing with their parents, must have gross family income equal to or less than 100 percent of the federal income official poverty line for a family of the same size. 1 OMM/ADM-6

There are Additional requirements in order to be eligible for Family Health Plus relating to the existence of heath care coverage and insurance. Prior to August 1, 2005, eligibility shall be determined without regard to resources.

Every person determined eligible for or receiving Family Health Plus coverage must enroll in a family health insurance plan.

Effective August 1, 2005, local social services districts must consider countable resources when determining eligibility for the Family Health Plus Program.

For the purposes of the Family Health Plus Program, resources are defined to have the same meaning as for the Medicaid program under section 366.2(a) of the Social services Law except that allowed savings shall mean at least 150% of the amount s permitted for households of the applicable allowable income amount permitted under Social Services Law 366.2(a)(7). Social

Services Law 369-ee.1(i). Determination of resources shall be in accordance with Section 366-a.2(b) and (c) of the Social Services Law. Social Services Law 369-ee.2(c).

Under Section 360-4.4 of the Regulations, resources include property of every kind within the control of the applicant or recipient, real and personal, tangible or intangible. Resources also include the value of property in the control of anyone acting on the applicant's/recipient's behalf such as a guardian, conservator, trustee, representative, or committee, as well as property transferred for less than fair market value. It may include the equity value of certain income-producing property, and certain resources of legally responsible relatives.

Individuals may attest to the amount of their resource. Social Services Law 366-a.2(b) 05 OMM/ADM-4. Countable resources are those items required to be considered, after first applying ADC-related resource disregards for parents and step-parents and 19 and 20 year olds, and the S/CC-related resource disregards for single individuals and childless couples. This includes applying the appropriate categorical treatment of income-producing property Individuals with resources in excess of the maximum level allowed will not be permitted to spenddown their resources in order to become eligible. 05 OMM/ADM-4

Except where otherwise established by law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, Food Stamp benefits or services, the social services agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

DISCUSSION

In this case the unrefuted evidence establishes that the Appellant was in receipt of a Medical Assistance authorization subject to no monthly excess income, and that by a notice entitled "Notice of Acceptance of Your Medical Assistance Application" dated June 11, 2007 the Agency informed the Appellant of its determination that the Appellant's excess income is $131.00 monthly. Said Notice does not set forth a proposed date of reduction of ten days subsequent to the date of the Notice and the Agency failed to establish that it was mailed at least 10 days before the date upon which the proposed action is to become effective. It is therefore not timely as defined in the Regulations. In addition, said Notice does not contain the previous amount of spenddown, does not contain information about the action the social services agency proposes to take or is taking, and does not inform the Appellant of the circumstances under which Medical Assistance will be continued or reinstated until the fair hearing decision is issued. Therefore, it is not adequate as defined in the Regulations. Furthermore, since the Appellant was receiving a Medical Assistance Authorization subject to excess income in the amount of $0.00 monthly, the Agency was required to send a Notice of Intent to Reduce her Medical Assistance Authorization. The Agency's failure to give timely and adequate notice of its proposed actions violates the Regulations and therefore its determination cannot be sustained.

The evidence at the hearing was that the Agency implemented the reduction of the Appellant's Medical Assistance authorization for the Appellant from June 1, 2007.

It is noted in passing that the evidence at the hearing was that, in addition to the lack of timely and adequate notice, the Agency's underlying decision was additionally defective in that it did not offer the Appellant the more preferable of SSI-related or LIF/ADC budgeting as required by Administrative Directive 91 ADM-27, did not offer the Appellant an opportunity to exclude a child with income from the Medical Assistance case, and did not evaluate the Appellant's eligibility for Family Health Plus benefits.

DECISION AND ORDER

The Agency's June 11, 2007 to reduce the Appellant's Medical Assistance authorization by a "Notice of Acceptance of Your Medical Assistance Application" was not correct and is reversed.

1. The Agency is directed to restore the Appellant's Medical Assistance authorization for the Appellant subject to $0.00 monthly excess income from June 1, 2007.

2. The Agency is directed continue to provide the Appellant with a Medical Assistance authorization for the Appellant subject to $0.00 monthly excess income.

Should the Agency in the future determine to implement its previous determination with respect to the Appellant's Medical Assistance benefits it is directed to issue a timely and adequate Notice of Intent.

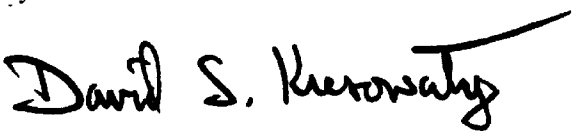
Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
11/07/2007

NEW YORK STATE
DEPARTMENT OF HEALTH

By



Commissioner's Designee

MAP-2087N (face)
02/4/05

IMPORTANT

The CITY of NEW YORK
Human Resources Administration
Medical Assistance Program

4 of 4/1

NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION
(RVI)

DATE: 6/11/07

CASE/CIN NUMBER(S): [redacted]

HOSPITAL/RHCF ADMISSION DATE: _____

HRA InfoLine: 1-877-472-8411

[redacted]

Dear Consumer:

told I. We are sending you this notice to tell you that effective _____, this Department will accept your Medicaid application for

for the level of coverage indicated in Section II below. (Any member of your household approved for a different type or level of coverage will receive a separate notice.) We will provide:

☐ Medicaid coverage for the following persons: _____

☐ Medicaid coverage for the period of _____ to _____ to pay for medical bills in excess of

☑ your monthly Spenddown (Excess Income) of $ 131.00

☐ your monthly NAMI (Net Available Monthly Income) Of $ _____

should be paid to: ☐ The Medical Assistance Program ☐ The Residential Health Care Facility ☐ The Hospital

This: ☐ includes inpatient Medicaid coverage ☐ does not include inpatient Medicaid coverage.

See the enclosed MAP-2060 **Budget Explanation**, to see how we determined your eligibility for benefits and the enclosed MAP-931, **Explanation of the Excess Income Program** and MAP-931A, **Optional Pay-In Program for Individuals with Excesses Income.**

II. You have been found eligible for the following level of coverage:

☐ **All Covered Care and Services** - You are eligible for **All Medicaid Covered Care and Services including** hospital care (if your coverage has been approved with a monthly spenddown, you are only covered for hospital services if we have checked the "includes inpatient Medicaid coverage box" in Section I, above), clinic care, emergency care, care by a primary doctor, lab tests and x-rays, prescription drugs, medical transportation, medical surgical supplies and long-term care services.

☑ **Community Coverage With Community-Based Long-Term Care** – You are eligible for community services such as doctor, hospital care (if your coverage has been approved with a monthly spenddown, you are only covered for hospital services if we have checked the "includes inpatient Medicaid coverage box" in Section I, above) and clinic care. You are eligible for lab tests, prescription drugs and community-based long-term care services such as personal care and Certified Home Health Agency services. You are also eligible for one short-term rehabilitative stay in a nursing facility in any 12-month period, not to exceed 29 days. You are **not eligible** for nursing home care other than short-term rehabilitation. You are also **not eligible** for alternate level of care provided in a hospital, hospice in a nursing home, intermediate care facility services, managed long-term care in a nursing home, home and community-based waiver services provided through the Long-Term Home Health Care Program, Traumatic Brain Injury Waiver Program, Care at Home Waiver Program, or Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.

☐ **Community Coverage Without Long-Term Care** - You are eligible for community services such as doctor, hospital care (if the "includes inpatient Medicaid coverage box" in Section I above is checked) and clinic care. You are eligible for lab tests and prescription drugs. You are also eligible for one short-term rehabilitative stay in a nursing facility and for one commencement of Certified Home Health Agency services in any 12-month period, each not to exceed 29 days. You are **not eligible** for nursing home care or Certified Home Health agency services beyond the one admission/commencement of each, per 12-month period. You are **not eligible** for alternate level of care provided in a hospital, hospice in a nursing home, intermediate care facility services, managed long-term care in a nursing home, home and community-based waiver services provided through the Long-Term Home Health Care Program, Traumatic Brain Injury Waiver Program, Care at Home Waiver Program, or Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program. You are also **not eligible** for the following Community-Based Long-Term Care Services: adult day health care, care other than short-term rehabilitation, hospice in the community, residential treatment facility services, personal care services, assisted living program, managed long-term care in the community, home and community-based waiver services programs, limited licensed home care, private duty nursing, personal emergency response services and consumer directed personal assistance program.

If you need more coverage than the level approved, you will need to submit additional resource documentation (see the explanation under the second "check box" below). You can request an increase to your coverage level at any time by visiting the Medical Assistance Program office of your choice and submitting the needed documentation. See the enclosed M-58d, List of Medical Assistance Program Offices.

III. The reason for this decision is as follows:

☑ You requested that we determine your Medicaid eligibility for level of coverage checked above or you do not have a resource test;

☐ You requested that we determine your Medicaid eligibility for either All Covered Care and Services or Community-Based Long-Term Care, but you failed to provide proof/sufficient proof of your resources. You failed to document the following:

_____

for the ☐ current month (month of application) ☐ Look-back period of _____ to _____

Please review the Medical Assistance Utilization Threshold information in the booklet, LDSS-4148 that was given to you when you applied for assistance.

If you submitted paid medical bills for direct reimbursement, you will be notified separately of our decision. The Laws and/or Regulations which allow us to do this are: Social Services Law 366-a(2) and 18 NYCRR 360-2.3, 360-4.1, 360-4.4, 360-4.5, 360-4.7, 360-4.8.

Worker	Section	Date
[signature]	523	6/11/07

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

MAP-2087N (reverse)
Rev. 02/04/05

CONFERENCE AND FAIR HEARING INFORMATION

Human Resources Administration
Medical Assistance Program

CONFERENCE: (Informal meeting with us): If you think our decision was wrong or if you do not understand our decision, please call us at 212-630-0996, or write to us at Medical Assistance Program, Conference Unit, 330 W. 34th Street, Third Floor, New York, NY 10001, to arrange a meeting. Sometimes this is the fastest way to solve any problems you may have. We encourage you to do this even when you ask for a fair hearing. This is not the way to request a fair hearing. If you ask for a conference, you are still entitled to a fair hearing.

STATE FAIR HEARING - **Deadline for Request**: If you want the State to review our decision about your Medical Assistance you must ask for a fair hearing within 60 days from the date of this notice.

HOW TO REQUEST A FAIR HEARING	
WRITE	Complete the section below and mail this notice to: NYS, OTDA, Office of Administrative Hearings, P.O. Box 1930, Albany, New York 12201-1930. (Please keep a copy for yourself)
CALL	800-342-3334 (Please have this notice with you when you call)
FAX	Complete the section below and fax both sides of this notice to Fax No. 518-473-6735
ONLINE	http://www.otda.state.ny.us/oah/forms.asp
WALK-IN	Bring this notice to the New York State Office of Temporary and Disability Assistance at 14 Boerum Place, Brooklyn, New York, or 330 West 34th Street, Third Floor, NY, New York.

If you cannot reach the State by phone or fax, be sure you write or come in before the hearing request deadline.

REQUEST FOR A FAIR HEARING

☐ I want a Fair Hearing. The agency's action is wrong because:	
Name: (Please print)	Case Name:
Address:	Telephone Number:
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, 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. If you need an interpreter, please advise the State when you request the hearing.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society, other legal advocate group, or by checking your Yellow Pages under "Lawyers."

ACCESS TO YOUR FILES 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 send you free copies of the documents from your files, which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will send you free copies of other documents from your files 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 (212) 630-0996, or write to us at: Conference Unit, Medicaid Fair Hearing Division, 330 W. 34th Street, Third Floor, New York, NY 10001. If you want copies of documents from your case file, you should ask for them ahead of time. Usually, they will be sent to you within three working days of when you ask for them. If you make your request less than five working days before your hearing, your case file documents may be given to you at your hearing.

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 (212) 630-0996.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.