NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243

CESAR A. PERALES
Commissioner

[An Administrative Directive is a written communication to local Social Services Districts providing directions to be followed in the administration of public assistance and care programs.]

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL NO.: 84 ADM-41
Medical Assistance

TO: Commissioners of Social Services

SUBJECT: Standardized MA Only Notices

DATE: November 14, 1984

SUGGESTED DISTRIBUTION: Medical Assistance Staff

CONTACT PERSON: Any questions concerning this release should be directed to the Division of Medical Assistance by calling your County representative at 1-800-342-3715, ext. 3-7581, or the New York City office at (212) 587-4853.

I. PURPOSE

The purpose of this directive is to provide you with client notices which are mandated for use in informing applicants/recipients of medical assistance of the indicated eligibility decisions.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Social Services Law and Other Legal References	Bulletin/Chapter Reference	Miscellaneous Reference
83 ADM-27 81 ADM-55		NYCRR 355 358 360.3 360.14 360.15 360.18	SSL 366-a		DRG-IV-B

DSS-29E V. 8/82)

II. BACKGROUND

In recent years the Department has been challenged in the courts on a number of medical assistance eligibility issues. Many of these lawsuits concerned the fact that affected individuals were not provided with timely and adequate notice or of their rights to appeal.

As a result, this Department has designed notices which will ensure that all applicants/recipients of medical assistance are properly and fully advised of all aspects pertaining to their eligibility, including rights to appeal.

III. PROGRAM IMPLICATIONS

Local districts are to utilize the notices contained in this directive for all applicants/recipients of medical assistance except applicants and recipients in Residential Health Care Facilities. The notices have been designed in conformance with Social Services Law and the rules and regulations of this Department. They have been approved within the department and reviewed with representatives of Legal advocacy groups. These notices may be reproduced on local agency letterhead but shall not be locally modified.

IV. REQUIRED ACTION

A. ATTACHMENT I - NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION.

This notice is to be used to notify applicants for medical assistance of the decision to accept or deny, or of the client's withdrawal of, the application. Reasons, where indicated, are to be stated clearly and in conformance with Department rules and regulations.

- Full coverage requires the entry of authorization dates.

- Coverage with a surplus requires the entry of budget information.

- A denial requires the entry of a clearly stated reason.

- A withdrawal requires the entry of the reason as given by the applicant.

- All actions require the citation of the appropriate law and/or regulation.

- The worker must sign and provide title and telephone number.

B. ATTACHMENT II - NOTICE OF INTENT TO - DISCONTINUE - CHANGE - MEDICAL ASSISTANCE.

This form is to be used to notify clients of intended changes to their coverage. Reasons, where required, are to be stated clearly and in conformance with Department rules and regulations.

- A reduction or increase in coverage based on financial reasons requires an effective date and the entry of budget information. When there is a change from a surplus income to a fully eligible case, a zero ($0) should be entered in the new monthly surplus amount.

- The second box which may be marked "Reduce" on this form is to be used for determinations based on non-financial factors. An effective date and clearly stated reason - e.g. a member moves out of the household - must be entered.

- All actions require the citation of the appropriate law and/or regulation.

- The worker must sign and provide title and telephone number.

C. DISTRIBUTION

In the near future these statewide mandated notices will be available from this Department's Forms and Publication Unit. Pending the receipt of an initial supply of these notices by this Department, local districts shall utilize the attached client notification forms upon exhaustion of the agency's existing forms, but in no event later than 30 days from receipt of this directive.

At the time of any determination which affects medical assistance eligibility two (2) copies of the appropriate notice must be sent to the client, and one copy must be maintained in the case record. A copy of the budget or MABEL printout should be sent with each Notice in order to provide an explanation of the budgetary methodology used to determine eligibility. Where there is Spanish readership, the Spanish version shall be developed and used by the local district.

V. EFFECTIVE DATE

This Directive will be effective on 12/1/84.

Robert C. Osborne
Deputy Commissioner
Division of Medical Assistance

ATTACHMENT I

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION

Case # Office # Unit # Worker # Name and Address of Agency; Center or District Office:

Case Name
(c/o name if present)
Address

_____

_____ _____
Notice Date County

WE ARE SENDING YOU THIS NOTICE TO TELL YOU THAT SOCIAL SERVICES WILL:

() - ACCEPT - your Medicaid application for FULL medical coverage from _____ to _____.

() - ACCEPT - your Medicaid application with a SPENDDOWN.

Your total monthly income is $_____. Your total monthly deductions are $_____. The allowable level for a family household your size is $_____. This difference between your net income and this level is $_____. This is called your monthly surplus income. You have surplus income of $_____ monthly. If your medical expenses equal this amount in any month, MA will pay those covered medical expenses incurred during the month which are more than your surplus income amount. If you have an inpatient hospital bill more than $_____ (your surplus income for six months) you can also receive Medicaid (MA) coverage.

() - ACCEPT - your Medicaid application for inpatient hospital care only from _____ to _____ for catastrophic illness computed as follows: _____
_____

() - DENY - your Medicaid application because: _____
_____

() - TAKE NO ACTION - on your Medicaid application since it was withdrawn at the request of _____

The law or regulation which allows us to do this is: _____
_____

Signature of Worker: _____ Telephone: _____

Name of Worker: _____ Title: _____

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

We will review this decision with you if you call us and ask for a LOCAL CONFERENCE. You also have the right to ask for a STATE FAIR HEARING. You must request a STATE FAIR HEARING within 60 days of the date on the top of this Notice. You must meet this deadline to request a STATE FAIR HEARING even if you ask for a LOCAL CONFERENCE first. The STATE FAIR HEARING is held by the New York State Department of Social Services.

BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION
****

THESE ARE THE WAYS TO ASK FOR AN APPEAL

REQUEST A LOCAL CONFERENCE

You can have a LOCAL CONFERENCE with us to review the decision we have made which is described on the other side of this Notice. If you want a conference to discuss your case, please call us as soon as you can. At the conference we will review our decision and answer any questions you have. Also, if we discover we have made the wrong decision or in view of information presented at the conference we determine to change the decision, we will change it and give you a new Notice.

If you want a LOCAL CONFERENCE call us at _____. This number should be used for requesting a LOCAL CONFERENCE. This is not the telephone number to be used to request a STATE FAIR HEARING. Even if you request a conference you can still request a STATE FAIR HEARING. Also, if you disagree with results of the LOCAL CONFERENCE, you can ask for a STATE FAIR HEARING.

REQUEST A STATE FAIR HEARING

If you think our decision is wrong, you can call or write and ask for a STATE FAIR HEARING. **DO ONLY ONE OF THE FOLLOWING:**

1. Call _____ to ask for a STATE FAIR HEARING. Please have this Notice with you when you call so the person taking your call can ask you for the information that is written on it; or

2. Send a copy of this Notice to this address and keep a copy.

   Fair Hearing Section
   New York State Department of Social Services
   P.O. Box 1930
   Albany, New York 12202

   When you send a copy of this Notice, please fill out the information requested below on the copy you send in:

I want a STATE FAIR HEARING because I believe the Decision on this Notice is wrong. I think it is wrong because: _____

_____

_____

Signature: _____ Date: _____

Telephone Number: Area Code: _____ Number: _____

If you request a STATE FAIR HEARING, a notice will be sent to you informing you of the time and place of the hearing. At the hearing you have the right to be represented by an attorney or other representative. 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 and present evidence against you. You also have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents that may be helpful in presenting your case.

HOW TO GET LEGAL HELP FOR YOUR LOCAL CONFERENCE OR STATE FAIR HEARING

If you need legal help for your LOCAL CONFERENCE or for your STATE FAIR HEARING and you cannot afford to pay for an attorney, you may be able to get free legal assistance by contacting: _____

ATTACHMENT II

NOTICE OF INTENT TO: DISCONTINUE - CHANGE MEDICAL ASSISTANCE

Case # Office # Unit # Worker # Name and Address of Agency; Center or District Office:

Case Name
(c/o name if present)
Address

_____

_____ _____
Notice Date Effective Date County

THIS AGENCY IS SENDING YOU THIS NOTICE TO TELL YOU THAT SOCIAL SERVICES WILL:

() - REDUCE - your Medical Assistance (MA) coverage starting _____.
() - INCREASE - your Medical Assistance (MA) coverage starting _____.

Your total monthly income is $_____. Your total monthly deductions are $_____. The difference between these is your monthly NET income for Medicaid. This is $_____. The allowable level for a family household your size is $_____. The difference between your net income and this level is $_____. This is called your monthly surplus income. Your monthly surplus income has changed from _____ to _____. You have surplus income of $_____ monthly. If your medical expenses equal this amount in any month, MA will pay those covered medical expenses incurred during the month which are more than your surplus income amount. If you have an inpatient hospital bill more than $_____(your surplus income for six months) you can also receive Medicaid (MA) coverage.

() - DISCONTINUE - your Medical Assistance (MA) coverage on _____ because: _____

() - REDUCE - your Medical Assistance (MA) coverage on _____ because:
_____

The law or regulation which allows us to do this is: _____
_____

Signature of Worker: _____ Telephone: _____

Name of Worker: _____ Title: _____

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

We will review this decision with you if you call us and ask for a LOCAL CONFERENCE. You also have the right to ask for a STATE FAIR HEARING. You must request a STATE FAIR HEARING within 60 days of the notice date on top of this Notice. You must meet this deadline to request a STATE FAIR HEARING even if you ask for a LOCAL CONFERENCE first. The STATE FAIR HEARING is held by the New York State Department of Social Services.

If you request a STATE FAIR HEARING before the effective date of this Notice, you will continue to receive your Medical Assistance unchanged until the STATE FAIR HEARING decision is issued. A request for a LOCAL CONFERENCE alone will not result in a continuation of benefits.

BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION
****

THESE ARE THE WAYS TO ASK FOR AN APPEAL

REQUEST A LOCAL CONFERENCE

You can have a LOCAL CONFERENCE with us to review the decision we have made which is described on the other side of this Notice. If you want a conference to discuss your case, please call us as soon as you can. At the conference we will review our decision and answer any questions you have. Also, if we discover we have made the wrong decision or in view of information presented at the conference we determine to change the decision, we will change it and give you a new Notice.

If you want a LOCAL CONFERENCE call us at _____. This number should be used for requesting a LOCAL CONFERENCE. This is not the telephone number to be used to request a STATE FAIR HEARING. Even if you request a conference you can still request a STATE FAIR HEARING. Also, if you disagree with results of the LOCAL CONFERENCE, you can ask for a STATE FAIR HEARING.

REQUEST A STATE FAIR HEARING

If you think our decision is wrong, you can call or write and ask for a STATE FAIR HEARING. **DO ONLY ONE OF THE FOLLOWING:**

1. Call _____ to ask for a STATE FAIR HEARING. Please have this Notice with you when you call so the person taking your call can ask you for the information that is written on it; or

2. Send a copy of this Notice to this address and keep a copy.

   Fair Hearing Section
   New York State Department of Social Services
   P.O. Box 1930
   Albany, New York 12202

   When you send a copy of this Notice, please fill out the information requested below on the copy you send in:

I want a STATE FAIR HEARING because I believe the Decision on this Notice is wrong. I think it is wrong because: _____

_____

_____

Signature: _____ Date: _____

Telephone Number: Area Code: _____ Number: _____

If you request a STATE FAIR HEARING, a notice will be sent to you informing you of the time and place of the hearing. At the hearing you have the right to be represented by an attorney or other representative. 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 and present evidence against you. You also have the right to bring witnesses to speak in your favor. You should bring to the hearing any documents that may be helpful in presenting your case.

HOW TO GET LEGAL HELP FOR YOUR LOCAL CONFERENCE OR STATE FAIR HEARING

If you need legal help for your LOCAL CONFERENCE or for your STATE FAIR HEARING and you cannot afford to pay for an attorney, you may be able to get free legal assistance by contacting: _____