HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION AUTHORIZATION

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) has been:

AUTHORIZED effective on _____. The services you are authorized to receive are identified in your Service Plan and will be reassessed at least every six (6) months.

The laws that allow us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the NYS Social Services Law

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to 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 statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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 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 the 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.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society of other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyer.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they 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 the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

New York State Department of Health
Division of Home and Community Based Services

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
DENIAL OF WAIVER PROGRAM

Name & Address of Waiver Applicant:

Client Identification Number (CIN): _____

Notice Date: _____

This is to inform you that your application for participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) has been **DENIED.**

Your participation in the NHTD waiver has been **DENIED** for the following reason(s):

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

cc: Legal Guardian
Authorized Representative
NYS DOH NHTD Waiver Program
Service Coordinator
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to 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 statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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 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 the 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.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society of other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyer.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they 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 the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

New York State Department of Health
Division of Home and Community Based Services

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF INTENT TO DISCONTINUE FROM THE WAIVER PROGRAM

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____ Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** because you have chosen to no longer receive waiver services(s).

Explanation:

_____

_____

The laws that allows us to do this are:

Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social NEW Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits)

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 statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**
2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**
3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.
4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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 the 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.

☐ I want a fair hearing. The decision is wrong because: _____

_____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated on the front page of this Notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the Fair Hearing, New York State may recover the cost of any Medical Assistance benefits that you should not have received.

☐ I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

If you do NOT want your Medical Assistance benefits to continue while waiting for the decision of the fair hearing, check the box below and send this page to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York, 12201.

☐ I do NOT want to continue my Medical Assistance benefits while waiting for the decision of the Fair Hearing. I understand if I lose the Fair Hearing I may be responsible for the cost of any Medical Assistance benefits that the Fair Hearing determines I should not have received.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they 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 the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF INTENT TO DISCONTINUE FROM THE WAIVER PROGRAM

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____ Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** because:

☐ You are determined to no longer be eligible for nursing home level of care, per H/C Patient Review Instrument and SCREEN.

☐ Waiver services cannot safely maintain you in the community.

☐ You do not have a current Service Plan.

☐ Other: _____

Explanation:

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits)

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 statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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 the 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.

☐ I want a fair hearing. The decision is wrong because: _____

_____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated in this notice, you will continue to receive your Medical Assistance benefits unchanged until the Fair Hearing decision is issued. However, if you lose the Fair Hearing, you may have to pay back any Medical Assistance benefits you should not have received while waiting for the decision.

☐ I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

If you do not want your Medical Assistance benefits to continue until the Fair Hearing decision is issued, you must tell the State when you call for a Fair Hearing, **or** if you send back this notice, check the box below:

☐ I do not want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they 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 the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

New York State Department of Health
Division of Home and Community Based Services

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION PROGRAM (NHTD)

NOTICE OF DECISION
REDUCTION AND/OR DISCONTINUATION OF WAIVER SERVICE(S)

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

This notice is for waiver services approved for _____ to _____ as established in your most recent service plan.

1a. ☐ No reduction in waiver services is indicated at this time.
1b. The following waiver service(s) will be **reduced** as of the Effective Date of this notice.

_____	from _____	to _____	
waiver service	hours/frequency	hours/frequency	
_____	from _____	to _____	
waiver service	hours/frequency	hours/frequency	
_____	from _____	to _____	
waiver service	hours/frequency	hours/frequency	

2a. ☐ No discontinuation of waiver services is indicated at this time.
2b. The following waiver service(s) will be **discontinued** as of the Effective Date on this notice.

_____	_____
waiver service	waiver service
_____	_____
waiver service	waiver service
_____	_____
waiver service	waiver service

3a. We intend to take the action(s) identified above because:

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____ _____
Address Telephone

_____
Address

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits).

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2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING.

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☐ I want a fair hearing. The decision is wrong because:_____

_____

CONTINUING YOUR BENEFITS: If you request a Fair Hearing before the Effective Date stated in this notice, you will continue to receive your Medical Assistance benefits unchanged until the Fair Hearing decision is issued. However, if you lose the Fair Hearing, you may have to pay back any Medical Assistance benefits you should not have received while waiting for the decision.

☐ I want to continue my Medical Assistance benefits until the Fair Hearing decision is issued for (specify action(s) from changes on page 1 above):

_____

_____

_____

If you do not want your Medical Assistance to continue until the Fair Hearing decision is issued, you must tell the State when you call for a Fair Hearing, **or** if you send back this notice, check the box below:

☐ I do not want to continue my Medical Assistance benefits until the Fair Hearing decision is issued.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they 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 the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
INCREASE AND/OR ADDITION OF WAIVER SERVICE(S)

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

This notice is for waiver services approved for _____ to _____ as set forth in your most recent service plan:

1a. ☐ No increase in waiver service(s) indicated at this time.
1b. The following waiver service(s) will be **increased** as of the Effective Date of this notice:

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

_____ from: _____ to: _____
waiver service hours/frequency hours/frequency

2a. ☐ No addition of waiver service(s) indicated at this time.
2b. The following waiver service(s) will be **added** as of the Effective Date of this notice:

_____ at: _____
waiver service hours/frequency

_____ at: _____
waiver service hours/frequency

_____ at: _____
waiver service hours/frequency

3. We intend to take the action(s) identified above because:

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE REST OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____ _____
Name of Regional Resource Development Center (RRDC) Telephone

_____
Address

cc: Legal Guardian
Authorized Representative
Service Coordinator

RIGHT TO 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 the Regional Resource Development Specialist (RRDS) discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to 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 statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a Fair Hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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 the 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.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyers.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they 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 the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

New York State Department of Health
Division of Home and Community Based Services

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
SUSPENSION

Client Identification Number (CIN): _____

Name and Address of Waiver Participant

Notice Date: _____

Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) is being **SUSPENDED** as of the Effective Date above.

Your participation in the waiver is being **SUSPENDED** because:

☐ You have been hospitalized;

☐ You have been admitted into a Nursing Home;

☐ You are incarcerated;

☐ You have been admitted into an inpatient psychiatric or substance abuse facility;

☐ You have been admitted into an Intermediate Care Facility for persons with developmental disabilities

☐ Other: _____

Explanation:

_____

_____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and, Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to 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 statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp **OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

5. **New York City participants ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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 the 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.

☐ I want a fair hearing. The decision is wrong because: _____

_____

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under “lawyers.”

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they 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 the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTICE OF DECISION
DENIAL OF A WAIVER SERVICE and/or
DENIAL OF A WAIVER PROVIDER

Name & Address of Waiver Participant:

Client Identification Number (CIN): _____

Notice Date: _____

Effective Date: _____

1. Your request for the following NHTD waiver service(s) has been denied:

Service(s) requested: _____

We intend to take this action because:

2. Your request for the following NHTD waiver provider has been denied:

Provider requested: _____

We intend to take this action because: _____

The laws that allows us to do this are:
Section 1915(c) of the Social Security Act and Section 366 (6-a) of the Social Services Law.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE REST OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Legal Guardian
Authorized Representative
Service Coordinator
NYS DOH NHTD Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the RRDS discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

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   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.
4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary Disability Assistance, P. O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.
5. **New York City ONLY:** You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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☐ I want a fair hearing. The decision is wrong because: _____

_____

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INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER
FOR
NURSING HOME TRANSITION AND DIVERSION (NHTD)

NOTIFICATION OF DEATH OF A WAIVER PARTICIPANT TO LOCAL DEPARTMENT OF SOCIAL SERVICES

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____

This is to inform you that the individual name above is discontinued from the Nursing Home Transition and Diversion waiver due to the death of the waiver participant on _____.
(date)

_____ _____
Regional Resource Development Specialist (Signature) Regional Resource Development Specialist (Print)

_____
Name of Regional Resource Development Center (RRDC)

_____
Address

_____
Address

_____
Telephone

cc: Service Coordinator
NYS DOH NHTD Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)