

**IMPORTANT NOTICE CONCERNING YOUR CONTRIBUTION TOWARD CHRONIC CARE**

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN/RID NUMBER	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ ----- <b>OR</b> Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____		
CASE NAME (And C/O Name if Present) AND ADDRESS				
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We were recently informed of a change in your income and/or circumstances which requires us to recalculate your monthly contribution toward the cost of your care (NAMI).

Your monthly income for cost of care changed from \$ \_\_\_\_\_ to \$ \_\_\_\_\_, effective \_\_\_\_\_ due to \_\_\_\_\_

Because this income change was not budgeted for \_\_\_\_\_ month(s), we are adjusting the amount you are required to contribute in the future toward the cost of your care. The following is an explanation of how we calculated the adjustment in your contribution for the periods indicated:

- A. Your Revised NAMI is \$ \_\_\_\_\_
- B. Your Previous NAMI was \$ \_\_\_\_\_
- C. The Difference is \$ \_\_\_\_\_
- D. The Number of Months for which this income difference was not budgeted is \_\_\_\_\_ month(s)  
(From \_\_\_\_\_ to \_\_\_\_\_)
- E. Total Amount of the Income Adjustment is \$ \_\_\_\_\_

In order to make this adjustment, the total monthly income contribution required towards the cost of care will INCREASE/DECREASE from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ effective \_\_\_\_\_; and your monthly income contribution effective \_\_\_\_\_ will be \$ \_\_\_\_\_. Starting \_\_\_\_\_ your monthly income contribution will be \$ \_\_\_\_\_.

The LAW(S) AND/OR REGULATION(S) which allow us to do this is Section 366 of the Social Services Law and 18 NYCRR 360-4.9, 360-4.3 AND 360-4.10

The enclosed budget worksheet(s) explains these calculations.

**ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call Verizon, toll free at 1-800-555-5000.**

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

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

Enclosure

cc: \_\_\_\_\_  
Name of Medical Facility

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe that the above action is wrong, you may request a State fair hearing by:

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

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

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

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuylar, Seneca, Steuben, Wayne or Yates County:**  
(716) 266-4868

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

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

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

**OR**

(2) **Writing:** By sending a copy of this notice completed, to the Office of Administrative Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

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Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

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

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**CONTINUING YOUR BENEFITS:** If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file, 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 the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.