NOTICE OF DECISION ON YOUR REQUEST FOR COVERAGE OF NURSING FACILITY SERVICES
LIMITED COVERAGE
(Transfer of Assets Penalty)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN NUMBER	
CASE NAME (and C/O Name if Present)AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ **OR** Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We will change your Medical Assistance coverage from Community Coverage to limited coverage effective _____.

This is because you requested an increase in Medical Assistance coverage for nursing facility services, but we have determined that on (date) _____ you/your spouse transferred (item(s)) _____ valued at $_____. The difference between this value and the amount actually received ($_____) is $_____. This amount is considered to be the uncompensated value.

Because you/your spouse transferred this asset(s) for less than fair market value, you are not eligible for the following types of care and services:

- services provided in skilled nursing facilities, including hospice and managed long-term care, health-related facilities, or intermediate care facilities;
- nursing facility services provided in a hospital; and
- home and community-based services provided pursuant to a waiver under Section 1915(c) or (d) of the Social Security Act.

You are **not** eligible for the above noted care and services for a period of _____ month(s) or until (date) _____. This is based on the following calculation:

Uncompensated value of transferred asset(s) $_____
(less MA exemption, if applicable)

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Monthly regional rate $_____

Period of limited coverage: _____ month(s)

You will also have an additional $_____ that you will have to contribute toward your cost of care for the month of _____. This is the partial month portion of the penalty period. This is in addition to any income contribution that must be contributed toward your cost of care for the month.

Although you are not eligible for certain types of care and services because of the above-referenced transfer, you may be eligible for coverage of other care and services, (*e.g., eyeglasses, hearing aids, dentures and acute hospital care*). In order for you to be eligible for this coverage: (1) your income must be no greater than the allowable MA income standard; or (2) if your income exceeds the allowable MA income standard you must meet certain excess income requirements. You will have to meet an excess income requirement for these services if there is an ☒ in the box below.

❑ **EXCESS INCOME**
Your total gross monthly income is $_____. Your total monthly deductions are $_____. The difference between these is your net monthly income. This is $_____. The allowance income standard for a family household your size is $_____. The difference between your net monthly income amount and this standard ($_____) is your monthly spenddown or excess income amount. Your excess income for six months is $_____. Please see the enclosed Form LDSS-4038, which explains how you can meet the excess income requirements and become eligible for coverage under the EXCESS INCOME PROGRAM.

Note: If there are other factors which affect your Medical Assistance coverage, a separate notice is enclosed.

READ THE ENCLOSED NOTICE (Effect of Transfer of Asset(s) on Medical Assistance Eligibility) FOR IMPORTANT INFORMATION CONCERNING TRANFER OF ASSETS.

The Laws and/or Regulations which allow us to do this are: Social Services Law 366.5 and 18 NYCRR 360-4.4, 360-4.5, 360-4.7 and 360-4.8.

We have enclosed a budget worksheet(s) so that you can see how we determine eligibility for benefits.

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

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

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the 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. 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 state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**

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

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, 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: _____

_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

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 first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, 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 page 1 of this notice or write us at the address printed at the top of page 1 of this notice.

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

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

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.