NOTICE OF TRANSITION OF YOUR MEDICAID/FAMILY HEALTH PLUS/FAMILY HEALTH PLUS-PREMIUM ASSISTANCE PROGRAM/FAMILY PLANNING BENEFIT PROGRAM AND/OR MEDICARE SAVINGS PROGRAM COVERAGE (County A)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN/RID 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.

This is to inform you that we will continue Medicaid/Family Health Plus/Family Health Plus-Premium Assistance Program/Family Planning Benefit Program and/or Medicare Savings Program coverage for name(s) _____ _____ until _____.

Because you have informed us of your move, your case will be transferred to your new district of residence effective _____. You will receive more information about your coverage from your new district.

Important Information for Family Health Plus Enrollees

You will continue to be a member of your current Family Health Plus plan until the effective date above. You will be enrolled in the same plan if this plan is offered in your new county. If your current plan is not available in your new county, you will be assigned a new health plan. If you have any questions about your health plan enrollment, call the managed care unit in your new local social services district.

Important Information for Family Health Plus-Premium Assistance Program Enrollees

Individuals who are enrolled in cost effective Employer Sponsored Health Insurance will continue to be eligible for the Family Health Plus-Premium Assistance Program until the effective date above.

Important Information for Medicaid Managed Care Enrollees

You will be enrolled in the same Managed Care plan if your current plan is offered in your new county. If your current plan is not offered in your new county, you will need to use your New York State Benefit Identification Card to access medical care from a Medicaid provider after the effective date above.
If you are required to enroll in a new Medicaid Managed Care plan in your new county, you will be sent information about available plan selections. If you have questions about your health plan enrollment, call the managed care unit in your new local social services district.

Excess Income (Spenddown) Cases

For individuals whose income is over the allowable Medicaid income limit and who participate in the Excess Income Program, beginning _____, you will need to provide proof of paid or unpaid medical expenses to the Medicaid office in your new county. You may also pay your excess income amount to your new county.

Important Information for Family Planning Benefit Program Enrollees

Your enrollment in the Family Planning Benefit Program will continue until the effective date above.

Important Information for Medicare Savings Program Enrollees

Your enrollment in the Medicare Savings Program will continue until the effective date above.

This decision is based on Regulations 18 NYCRR 351.2(g)(1), 360-7.7 and 360-4.8(b) and Sections 364-j and 369-ee of the Social Services Law.

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

NOTICE OF TRANSFER OF YOUR MEDICAID

CONFERENCE AND FAIR HEARING INFORMATION

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 front 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. 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, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

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.

ATTENTION: Children under 19 years of age who are not eligible for Medicaid or other health insurance may be eligible for the Child Health Plus Insurance Plan (CHPlus). The plan provides health care insurance for children. Call 1-800-698-4543 for information.