NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

NOTICE OF DECISION ON YOUR MEDICAID APPLICATION

MEDICAID/FAMILY HEALTH PLUS DENIAL/FAMILY PLANNING BENEFIT PROGRAM DECLINATION

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.

We have denied your application for Medicaid/Family Health Plus dated _____ for:

(Name)_____ Client I.D. #_____

(Name)_____ Client I.D. #_____

(Name)_____ Client I.D. #_____

You were not eligible for Medicaid because:

☐ Your net income (gross income less Medicaid deductions) of $_____ is over the Medicaid income limit of _____. The amount over the Medicaid limit is called excess income or spenddown. Your monthly excess income amount is $_____. You do not have paid or unpaid medical expenses not covered by insurance that are equal to or more than your excess income amount. If you incur medical bills in the amount of your Medicaid excess income limit in the future, you may reapply. Please read the attached "Explanation of the Excess Income Program" and "Optional Pay-In Program".

☐ Your countable resources of $_____ are over the Medicaid resource limit of $_____. The amount over the resource limit is called excess resources or spenddown. Please read the attached "Explanation of the Excess Resource Program".

OR

☐ You are age 21 through 64, and are not pregnant or certified blind or disabled or caring for your related children under 21 years of age, and:
- ☐ your gross income of $_____ is over 185% of the Medicaid Standard of $_____.
- ☐ your net income (gross income less Medicaid deductions) of $_____ is over the Medicaid Standard of $_____.

For individuals age 19 through 64, we also evaluated your eligibility for Family Health Plus. You were not eligible for Family Health Plus for the reasons noted below:

☐ You are not eligible for Family Health Plus because your gross income of $_____ is over the Family Health Plus income limit of $_____.

☐ You are not eligible for Family Health Plus because you have other insurance. Family Health Plus is a health care program for people who do not have any other health insurance, except for very limited exceptions. You have a health insurance plan that is not one of these exceptions, and it is not cost effective for Medicaid to pay the premium for your Employer Sponsored Health Insurance Plan. Therefore, you are not eligible for Family Health Plus.

☐ You are not eligible for Family Health Plus because you are eligible for employer sponsored health benefits through a federal plan.

You are determined to be financially eligible for the Family Planning Benefit Program, because your net income (gross income less Medicaid deductions) is at or below $_____ , which is the Medicaid income limit for these services. **You have not been enrolled in the Family Planning Benefit Program, as you have chosen not to participate.**

Children up to age 19 may be eligible for Child Health Plus. Call 1-800-698-4543 for information.

Please be advised that you may reapply at any time in the future.

This decision is based on Sections 369-ee and 366(1)(a)(11) of the Social Services Law and 18 NYCRR 360-4.8.

We have enclosed a budget worksheet so that you can see how we determined your eligibility.

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

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.ny.gov/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 Child Health Plus Insurance. The plan provides health care insurance for children. Call 1-800-698-4543 for information.