Notice of Decision for Enrollment or Denial of Enrollment in the New York State 1915(c) Children's Waiver

Notice Date: ___________________ **CIN Number:** ___________________

MEMBER (CHILD/YOUTH)

Name: ____ **Date of Birth** (mm/dd/yyyy): _________________

C/O PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE, IF ANY

Name: ____

CARE MANAGEMENT AGENCY/HEALTH HOME

Name: ____

Address: ____

Telephone Number: ______________________________

This is to advise you that effective on _______________ (Date) this agency ______________________________________ (Name of Care Management Agency/Health Home)

☐ **Approved your application for Home and Community Based Services (HCBS) through the eligibility criteria of the 1915(c) Children's Waiver**

- ☐ You have been found eligible for the Children's Waiver and access to HCBS services can begin. Please note that HCBS eligibility is good for one year. To continue HCB services a new HCBS Eligibility Determination must be completed prior to: ______________ (Date).
- ☐ You have been found eligible for the Children's Waiver however, you have been placed on a waiting list pending an available slot.

This is to advise you that effective on _______________ (Date) this agency ______________________________________ (Name of Care Management Agency/Health Home)

☐ **Denied your application for Home and Community Based Services (HCBS) through the eligibility criteria of the 1915(c) Children's Waiver.** You do not meet the eligibility criteria necessary for enrollment in the Children's Waiver due to the following reason(s):

- ☐ You do not meet the Level of Care criteria of Target, Risk and Functional requirements necessary for enrollment in the waiver.
- ☐ You are over the age of 21.
- ☐ You receive HCBS services from another HCBS system (e.g. Office for People With Developmental Disabilities (OPWDD) or Managed Long-Term Care (MLTC)).
- ☐ You are expected to reside in an inpatient (e.g. Residential Treatment Facility, Nursing Home, Hospital, etc.) setting for 90 days or more.
- ☐ Other ____

This action is taken under HCBS Children's Waiver Authority NY 4125 and 42 CFR 441.302(c) and Social Services Law 366(6), 366(7), 366(9), or 366(12).

Signature of Health Home Representative: ____

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 to request a conference and/or a fair hearing.

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.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.
5. **Walk In (New York City):**
   Office of Temporary and Disability Assistance
   Office of Administrative Hearing
   5 Beaver Street,
   New York, New York 10004

   Walk In (Albany):
   Office of Temporary and Disability Assistance
   Office of Administrative Hearing
   40 N. Pearl Street
   Albany, New York 12201
6. **Speech and Hearing Impaired:** Contact the New York Relay Service at 711 or 1-800-622-1220. Request that the operator call 877-502-6155. Service at this number will only be provided to callers using TDD equipment.

☐ I want a Fair Hearing.
The Agency's action is wrong because ______________________________

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, health care bills, heating bills, medical verification, doctor's 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 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. If you call or write to us, we will also make available to you without charge specific policy materials necessary for you to decide whether to request a fair hearing or to prepare for the hearing. Policy materials that may be available to you include documents such as: Administrative Directives, General Information System messages, Informational Letters, portions of the Medicaid Reference Guide, Department of Health Medicaid Update newsletters and Local Commissioner Memorandums. To ask for specific policy materials, 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 free copies of specific policy materials or 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 2 of this notice or write to us at the address printed at the top of page 2 of this notice.

Print Name: ____

Client Identification Number (CIN): _______________

Address: ____

Telephone Number: __________________________

Signature: ____ **Date:** ______________________