NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Attachment X

NOTICE OF DECISION ON YOUR MEDICAID APPLICATION
(FAMILY PLANNING BENEFIT PROGRAM ACCEPTANCE)

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 accepted your application dated _____ for the Family Planning Benefit Program effective _____ for:

(Name)_____ Client I.D. #_____

(Name)_____ Client I.D. #_____

(Name)_____ Client I.D. #_____

This is because your gross income of $_____ is at or below $_____ which is the income limit for the Family Planning Benefit Program.

This means Medicaid will pay for family planning services only. Family planning services are services that may help prevent or reduce unwanted pregnancies. The Family Planning service package includes certain prescription and non- prescription drugs, medical supplies, transportation, sterilization and medical counseling.

If you do not want Family Planning services for yourself or anyone else you applied for, let your worker know.

We also evaluated your eligibility for Medicaid. The following individuals are not eligible for Medicaid.

☐ (Name)_____ Client I.D. #_____

(Name)_____ Client I.D. #_____

This is because your gross income of $_____ is over $_____ which is the allowable Medicaid income limit for single individuals/childless couples between 21 and 65 years of age, individuals between 19 and 20 years of age living on their own and parents of a child under age 21.

☐ (Name)_____ Client I.D. #_____

(Name)_____ Client I.D. #_____

This is because your gross income of $_____ is over $_____ which is the allowable Medicaid income limit for individuals under 19 years of age.

☐ (Name)_____ Client I.D. #_____

(Name)_____ Client I.D. #_____

This is because your gross income of $_____ is over $_____ which is the allowable Medicaid income limit for individuals between 19 and 20 years of age living with a parent or caretaker relative.

☐ You are not eligible for Medicaid with a spenddown because your gross income of $_____ is over the allowable Medicaid income limit of $_____. The amount over the limit is called excess income or spenddown. Your monthly excess income amount is $_____. We have not received documentation that you have paid or unpaid medical expenses not covered by insurance that are equal to or more than your excess income.

If you incur medical bills in the amount of your excess income or if your income goes down, you may reapply.

Please read the enclosed "Explanation of the Excess Income Program" and "Optional Pay-In Program."

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

This decision is based on Section 366(1)(b) of the Social Services Law.

If your income is too high for Medicaid coverage, you may still be able to get health care coverage.

Individuals and families who file or will file Federal taxes with incomes up to 400% of the FPL, which is equivalent to $45,960 for an individual and $94,200 for a family of four (based on 2013 FPLs), may be eligible for advance tax credits to help buy health insurance through New York's health benefit exchange, New York State of Health. If annual income is greater than 400% of the FPL, health insurance can still be purchased through New York State of Health.

If you need help in applying for health care coverage through the New York State of Health, assistance is available. Navigators and Certified Application Counselors are people trained to help you understand your health coverage options and enroll in a plan. Your local department of social services can also help you with your application and choices.

To learn more about New York State of Health and to find Navigators or Certified Application Counselors in your area, please call 1-855-355-5777 or visit our Web site at http://www.nystateofhealth.ny.gov/.

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.