

NEW YORK STATE DEPARTMENT OF HEALTH  
Office of Health Insurance Programs

**NOTICE OF INTENT TO DISCONTINUE MEDICAID**

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 have re-determined your eligibility for Medicaid coverage under the new rules of the Patient Protection and Affordable Care Act of 2010. Under these rules, we compared your gross income to the Medicaid eligibility income levels.

We will discontinue Medicaid effective \_\_\_\_\_ for the following individuals:

- (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. # \_\_\_\_\_  
(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. # \_\_\_\_\_  
(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."

- You are not eligible for the Family Planning Benefit Program, because your gross income of \$ \_\_\_\_\_ is over \$ \_\_\_\_\_, which is the income limit for the Family Planning Benefit 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 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.

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 Medicaid or other health insurance may be eligible for the Child Health Plus Insurance Plan for kids. The plan provides health care insurance for children. Call 1-800-698-4543 for information.