Attachment V

NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION (MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES)

Notice Date _____	Name and Address of Agency/Center or District Office
Case Number / CIN Number	
Case Name and Address	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP: _____ OR Agency Conference _____ Fair Hearing Information and Assistance (800) 342-3334 Record Access _____ Legal Assistance _____
Worker No. Office No. Unit No. OCP MBI-WPD	Worker Name Telephone No.

We will ACCEPT the Medical Assistance Application dated _____ for the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) effective _____, for _____.

Please review the Medical Assistance Utilization Threshold Fact Sheet, found in the Medical Assistance section of the booklet "LDSS-4148B: "What You Should Know About Social Services Programs". The Fact Sheet explains any services limitations. The LDSS-4148B was given to you when you applied for assistance.

This is because your net income (gross income less Medical Assistance deductions) of _____ is at or below the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) income limit of $ _____ (250% of the Federal Poverty Level) and your countable resources of _____ are at or below the resource limit of $10,000.

This means that you will be enrolled in the New York State MBI-WPD program, which will provide you with Medical Assistance coverage as long as you are:

- certified disabled; **and**
- are working; **and**
- are at least 16 but less than 65 years of age**; and**
- have net income at or below 250% of the Federal Poverty Level (FPL); **and**
- have resources at or below $10,000; **and**
- are meeting your premium payment obligations (if required).

NOTE: A PREMIUM PAYMENT WILL NOT BE REQUIRED AT THIS TIME. HOWEVER, IN 2005 NEW YORK STATE MEDICAID WILL IMPLEMENT A PREMIUM PAYMENT COLLECTION SYSTEM. IF YOUR NET INCOME IS BETWEEN 150% AND 250% OF THE FEDERAL POVERTY LEVEL YOU WILL BE REQUIRED TO PAY A PREMIUM. WHEN THE PREMIUM PAYMENT REQUIREMENT BECOMES EFFECTIVE YOU WILL BE NOTIFIED OF THE AMOUNT OF THE PREMIUM REQUIRED.

☐ Since you requested that we determine your Medicaid eligibility for all covered care and services INCLUDING community-based long-term care BUT NOT nursing facility services, we did not review your resources for the past 36 months (60 months for trusts) and you will not be covered for the following nursing facility services:

- Nursing home care that is expected to last at least 30 days; or
- Nursing home care provided in a hospital; or
- Home and community based waiver services; or
- Hospice in a nursing home; or
- Managed long-term care in a nursing home.

If you need nursing facility services, notify your local Department of Social Services. They will then arrange to review your resources for the past 36 months (60 months for trusts) to find out if you are eligible for Medicaid coverage for these services.

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

The LAW(S) AND/OR REGULATION(S) which allows us to do this is Sections 366(1)(a)(12) and 367-a(12)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

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: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

The new Statewide toll-free request number is (800) 342-3334 **OR**

(2) Fax: Send a copy of this notice to fax no. (518) 473-6735. **OR**

(3) On-Line: Complete and sending the online request form at: **https://www.otda.state.ny.us/oah/oahforms/erequestform.asp** **OR**
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, 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.