NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS

NOTICE OF INTENT TO CHANGE MEDICAID COVERAGE TO FAMILY HEALTH PLUS

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 will change your coverage from Medicaid to Family Health Plus for _____ _____ (name(s)). Your Medicaid coverage will end effective _____. Your Family Health Plus coverage will begin on _____.

This is because your gross income of $_____ is under the Family Health Plus income level of $_____, and your countable resources of $_____ is under the Family Health Plus resource limit of $_____.

We used either income and resource information that you provided to us, or income information we got from one or more computer matches. If you disagree with the amounts that we budgeted, contact your worker before the date that your Medicaid will end (shown above).
Please look at the budget calculation section to see how we figured your income.

Under Family Health Plus, you must enroll in a health plan to receive your medical services. You have either chosen or are currently enrolled in _____ as your health plan. We are processing your enrollment in this plan. The health plan will notify you of the date that you can start using the medical services provided by the plan. You will receive information from your Family Health Plus plan to tell you how to access the medical services covered by the plan. You will have 90 days from this date to change your plan for any reason. You can only do this if there is another health plan available in your area. After 90 days, you will not be able to change your health plan for the next 9 months, unless you have a good reason.

Family Health Plus provides health insurance coverage for a limited service package for certain individuals who are age 19 through 64, and who cannot get Medicaid because their income or resources are too high.

The services which are not covered under Family Health Plus, but are covered under Medicaid include: long term home health care, institutional long term care, personal care and non-emergency transportation.

(*Note: If you become pregnant after your enrollment in Family Health Plus is effective, you have a choice of remaining in Family Health Plus or enrolling in Medicaid. You should discuss this choice with your doctor and the local department of social services office so that you can make the decision that best meets your needs.)*

We evaluated your eligibility for the Medicaid service package. You were not eligible for Medicaid because:

Your net income (gross income less Medicaid deductions) of $_____ is over the Medicaid income limit of $_____.

You told us your countable resources are over the Medicaid resource limit of $_____. The amount over the resource limit is called excess resources or spenddown.

SPENDDOWN ELIGIBLES ONLY:
At the time of your interview for medical insurance coverage, the options of Family Health Plus and Medicaid with a spenddown were explained to you. You chose to participate in Family Health Plus rather than Medicaid with a spenddown. If you decide that you want to change to Medicaid with a spenddown, contact your worker. If you choose spenddown, you may need to verify your resources, if you have not already done so, since there is a resource limit.

Your gross income of $_____ is over 185% of the Public Assistance Standard of Need of $_____.

Your net income (gross income less Medicaid deductions) of $_____ is over the Public Assistance Standard of Need of $_____.

You told us your countable resources are over the Public Assistance resource limit of $ _____.

Persons who are age 21 through 64, and are not pregnant or certified blind or disabled or caring for their related children under 21 years of age, must meet the requirements of the Public Assistance Program in order to be eligible for Medicaid.

The law and/or regulation(s) which allow us to do this are 18 NYCRR 360-4.7, 360-4.8 and Section 369-ee of the Social Services Law.

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.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, 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 the Child Health Plus Insurance Plan (Child Health Plus). The plan provides health care insurance for children. Call 1-800-522-5006 for information.