

**NOTICE OF ACTION ON YOUR MEDICAID APPLICATION/BENEFITS  
(WITHDRAW/FAIL TO PROVIDE AUTHORIZATION FOR ASSET VERIFICATION)**

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 _____	
				-----	
				<b>OR</b> Agency Conference _____	
				Fair Hearing Information and Assistance _____	
				Record Access _____	
				Legal Assistance Information _____	
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.	

This Department has made a decision concerning eligibility under the Medical Assistance Program. We are sending this notice to tell you that this Department will:

DENY the Medicaid application dated \_\_\_\_\_ for (name(s)) \_\_\_\_\_

\_\_\_\_\_ because in order to get Medicaid, you and your spouse (if married) must provide a signed authorization allowing Medicaid to verify your and your spouse's resources with financial institutions.

We have received a request to revoke this authorization for you and/or your spouse. Because the authorization was revoked, you are not eligible for Medicaid.

We sent a letter to you asking you and/or your spouse (if married) or your legal representative(s) to sign this authorization. Because we did not receive a signed authorization for both you and your spouse (if married) by \_\_\_\_\_, you are not eligible for Medicaid.

Discontinue the Medicaid coverage effective \_\_\_\_\_ for Name(s)) \_\_\_\_\_

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If Medicaid is paying health insurance premiums, including Medicare, for you, payment of these premiums will be discontinued.

This decision is based on 42 U.S.C. 1396w and Section 366-a(2) 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 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.

**STATE FAIR HEARING - Deadline for Request:** If you want the State to review our decision about your Medical Assistance you must ask for a fair hearing within **60** days from the date of this notice.

**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.