

**FAMILY HEALTH PLUS  
NOTICE OF DECISION ON YOUR REQUEST  
TO DISENROLL FROM YOUR HEALTH PLAN FOR GOOD CAUSE (FH #234)**

<b>NOTICE DATE:</b>		<b>NAME AND ADDRESS OF AGENCY/CENTER DISTRICT OFFICE</b>				
<b>CASE NUMBER</b>	<b>CIN/RID NUMBER</b>					
<b>CASE NAME (And C/O Name if Present) AND ADDRESS</b>						
		<b>GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP</b> _____ ----- <b>OR</b> <b>Agency Conference</b> _____  <b>Fair Hearing Information and Assistance</b> _____  <b>Records Access</b> _____  <b>Legal Assistance Information</b> _____				
		<b>OFFICE NO</b>	<b>UNIT NO</b>	<b>WORKER NO</b>	<b>UNIT OR WORKER NAME</b>	<b>TELEPHONE NO</b>

**This office has reviewed your request to quit the Family Health Plus health plan you are now in.**

**Your request has been APPROVED** and will be effective after you pick a new health plan.

You can pick from other health plans. Facts about these plans are included with this notice. Please read about these plans, and pick a new plan, if you want to. If you have a provider you would like to see, please make sure he or she belongs to the health plan you want to choose and that he or she is accepting new patients.

If you decide to choose another health plan, complete and return the ENROLLMENT FORM to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you do not want to pick a new plan and do not return the form by \_\_\_\_\_, you will stay in the health plan you are in now.

**Your request has been DENIED** because:

There are no other health plans in your area. To continue to receive Family Health Plus you must stay enrolled in your current plan.

**You have to stay in your present plan** until \_\_\_\_\_ because your request was made more than ninety (90) days after you enrolled in your Family Health Plus plan and you are still in the initial enrollment period. On this date, you can pick a new plan if there is another plan available in your county.

**This action is taken under Social Services Law 369-ee. If you wish, you can have a meeting (conference) to talk about this action. If you think this action is wrong, you may ask for a State fair hearing." To learn how to do this, please read the back of this sheet that says "RIGHT TO CONFERENCE OR FAIR HEARING."**

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**RIGHT TO CONFERENCE OR FAIR HEARING**

**RIGHT TO A CONFERENCE:** You may have a meeting to review these actions. If you want a meeting, you should ask for one as soon as you can. Your health care will not stay the same because you ask for a meeting. At the meeting, if we learn that we took a wrong action, or if because of facts you tell us we decide to change our action, we will correct the action and give you a new notice. You may ask for a meeting by calling us at the number on the front page of this notice, or by sending a letter to the address on the top of the front page of this notice. This phone number is used only to ask for a meeting. It cannot be used to set up a fair hearing.

If you ask for a meeting, you still have a right to a fair hearing.

**RIGHT TO A FAIR HEARING:** If you believe that the action we have taken is wrong, you can ask for a State fair hearing by phone or by writing.

To phone, find the closest city to your home and use the phone number shown. Please have this notice with you when you call.

(716) 852-4868 Buffalo                      (716) 266-4868 Rochester                      (516) 739-4868 Hempstead  
(315) 422-4868 Syracuse(518) 474-8781 Albany

To write for a fair hearing: Fill in the space below and send a copy of this notice to:

Fair Hearing Section  
NYS Office of Temporary and Disability Assistance  
Fair Hearings  
P.O. Box 1930  
Albany, New York 12201

Please keep a copy for yourself.

**I want a fair hearing.** This action is wrong because \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client Signature: \_\_\_\_\_

Client print name here: \_\_\_\_\_

Client Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Case Number: \_\_\_\_\_ CIN Number: \_\_\_\_\_

**YOU MUST ASK FOR A FAIR HEARING WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE**

**IF YOU ASK FOR A FAIR HEARING,** the State will send you a notice with the time and place of the hearing. You have a right to bring a person to help you like a lawyer, a friend, a relative or someone else. At the hearing, this person can give the hearing officer something in writing or just tell why the action should not be taken. This person can also ask questions of any other people at the hearing. Also, you have a right to bring people to speak in your favor. If you have any papers that will help your case - pay stubs, receipts, health care bills, doctor's letters - bring them with you.

**IF YOU NEED FREE LEGAL HELP,** you may be able to get such help by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under Lawyers or call the number on the front of this notice.

**YOU HAVE A RIGHT TO SEE YOUR CASE FILE** to help you get ready for the hearing. If you call or write to us we will give you free copies of the documents from your files which we will give to the hearing officer. Also, if you call or write to us we will give you free copies of other documents from your file, which you may want for your fair hearing. To ask for these documents or to find out how to see your file, call the Records Access number on the front page or write to us at the address at the top of the front page. You should ask for them before the date of your fair hearing. Documents will be mailed to you only if you ask that they be mailed.

**FOR MORE INFORMATION ON YOUR CASE,** if you want to see your file, to find out how to ask for a fair hearing or to find out how to ask for copies of your file, call the number or write to the address on the top of the front page of this notice.

