OHIP-0011 (Rev. 9/08)

NOTICE OF DECISION FOR FAMILY HEALTH PLUS – PREMIUM ASSISTANCE PROGRAM

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	Unit or Worker Name	
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.

The Local Department of Social Services (LDSS) has made a decision concerning your eligibility for Family Health Plus Premium Assistance Program.

This Department will:

☐ **ACCEPT** the application dated _____ for (name(s)) _____.

Effective: _____,the premium assistance program will pay $_____ ☐weekly ☐bi-weekly ☐ monthly ☐quarterly

☐ **DENY** the application dated _____ for (name(s)) _____.

The reason for this action is as follows:

☐ It is not cost effective for Medicaid to pay the premium for your employer sponsored health insurance plan.

☐ **CONTINUE** the premium payment for (name(s))_____, effective _____.The premium assistance program will pay $_____☐weekly ☐bi-weekly ☐monthly ☐quarterly

☐ **TAKE NO ACTION** on the application dated _____, since it was withdrawn.

☐ **CHANGE** from Family Health Plus Managed Care to Family Health Plus Premium Assistance Program for (name(s)) _____. You will be disenrolled from _____Health Insurance Plan effective:_____ and enrolled in your Employer's Health Insurance Plan _____,effective: _____.The Premium Assistance Program will pay $_____☐ weekly ☐bi-weekly ☐monthly ☐quarterly

☐ **DISCONTINUE** Premium Assistance Program for (name(s))_____ Effective _____. The **reason** for this action is as follows:

☐ You no longer have access to your employer's health insurance plan; you will be enrolled into the Family Health Plus plan you chose on your application.

☐ You no longer have access to your employer's health insurance plan. You must complete the enclosed Family Health Plus Plan enrollment form and return it within 10 days to the address listed above if you want to receive Family Health Plus benefits.

☐ It is not cost effective for Medicaid to continue paying the premium for your employer sponsored health insurance plan. You must notify us **within 10 days** to tell us if you will remain in the employer sponsored health insurance and pay the cost of the premium yourself. If you fail to respond your coverage will end. If you choose to discontinue your health insurance, you must provide us with written proof of your termination date, and you must choose a Family Health Plus plan **within 10 days** if you want to receive Family Health Plus benefits.

☐ It is not cost effective to continue to pay for your premium.

If this application is being denied or discontinued for financial reasons, the following information explains the calculation of eligibility. The income, resources and allowable deductions/exemptions are as follows:

INCOME		**RESOURCES**	
Gross monthly income	$ _____	Countable resources	$ _____
Deductions	- $ _____	Exemptions	- $ _____
Net monthly income	$ _____	Net resources	$ _____
Allowable standard	$ _____	Allowable standard	$ _____
Excess income	$ _____	Excess resources	$ _____

The law(s) and/or regulation(s) which allow us to do this are SSL 369-ee.

If any of these actions were taken because of financial circumstances, we have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

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.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.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.