NOTICE OF INTENT

To Reduce Personal Care Services (Level I only) to 8 Hours per Week Due to State Law Requiring Automatic Change

NOTICE DATE:	EFFECTIVE 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.

This is to advise you that effective _____, this agency intends to:

☐ **REDUCE** YOUR PERSONAL CARE SERVICES

Because you are receiving only Level I services (nutritional and environmental support functions), your services have been reduced from_____ to _____ for the rest of your current authorization period, which ends on _____. Before that date, we will decide whether you still need Level I services and, if so, how much service you need.

We intend to take this action because: You are authorized to receive only Level I personal care services. A new State law that was effective April 1, 2011 provides that personal care services shall not exceed 8 hours per week for individuals whose needs are limited to nutritional and environmental support functions (Level I). [See Social Services Law 365-a(2)(e)(iv), as added by Laws of 2011, Chapter 59, Part H, Section 89]. This State law requires an automatic reduction in your personal care services to no more than 8 hours per week.

Important information: There is no right to a hearing when the sole issue involving your Medicaid is a State law requiring an automatic change that adversely affects some or all recipients. However, you have the right to request that a hearing be scheduled with your benefits to continue unchanged (aid-continuing) pending the hearing. The hearing officer may determine at the hearing that you did not have the right to a hearing and did not have the right to have your benefits continue unchanged until the hearing decision is issued because the sole issue at the hearing is the new State law that requires an automatic reduction in your Level I personal care services to no more than 8 hours per week. If this happens, we may recover the costs of any Medicaid you received before the hearing. If the hearing officer determines at the hearing that the sole issue is this State law requiring an automatic reduction in your Level I services, your services will be reduced to 8 hours until the hearing decision is issued.

The law and/or regulation(s) which allow us to do this are Social Services Law Section 365-a(2)(e)(iv); 18 NYCRR Sections 358-2.2(a)(15), 358-3.1(f)(4) and 358-3.6(a)(2)(ii); and 42 C.F.R. 431.230.

SIGNATURE OF WORKER

X

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 request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged. 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.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.

5) **New York City participants Only**: You may also walk-in to the Office of Administrative Hearings, of the Office of Temporary and Disability Assistance, 14 Boerum Place, Brooklyn, New York. Bring a copy of this notice with you.

☐ 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. 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. The plan provides health care insurance for children. Call 1-800-698-4543 for information.