

DEPARTMENT OF SOCIAL SERVICES

100 NORTH PEARL STREET, ALBANY, NEW YORK 12243

BARBARA B. BLUM
Commissioner



[An Administrative Directive is a written communication to local Social Services Districts providing directions to be followed in the administration of public assistance and care programs.]

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL NO.: 82 ADM- 5
[Medical Assistance]

TO: Commissioners of Social Services

SUBJECT: Rosenberg v. the City of New York, Blum, et al.

DATE: February 25, 1982

SUGGESTED DISTRIBUTION:

- Medical Assistance Staff
- Income Maintenance Staff
- Child Welfare Staff

CONTACT PERSON:

Any medical assistance questions concerning this release should be directed to Joseph R. Kudner by calling 1-800-342-3715, Ext. 4-9141 or your New York City medical assistance representative at (212) 488-7032. Questions concerning Income Maintenance should be directed to Bruce Bushart at 1-800-342-3715, Ext. 4-9326. Any questions concerning reimbursement, claiming, or fiscal should be directed to the Bureau of Local Financial Operations. Upstate - Richard Radzynski, 1-800-342-3715, Ext. 4-0192 and Metropolitan - Anthony Funigiello at (212) 488-4516.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Social Services Law and Other Legal References	Bulletin/Chapter Reference	Miscellaneous Reference
80 ADM 19 81 ADM 55		360.1 (a) 360.18 (b)(c) 360.3 (a) 360.15 350.1 355.1			42 CFR 435.18 (6) 435.903 435.919 435.930 "Dear Commissioner" Letter dated 12/10/81

(Rev. 5/78)

I. PURPOSE

The purpose of this release is to advise local districts of the Order of the U.S. District Court for the Southern District of New York and the procedures to be used in implementing prospective and retrospective policy changes as a result of the Order of the U. S. District Court for the Southern District in Rosenberg v. the City of New York, Blum, et al.

II. BACKGROUND

In New York State, since 1966, an applicant who was denied cash benefits had to file a separate application to obtain MA benefits. Similarly, a discontinuance of cash benefits meant a discontinuance of medical assistance in the majority of cases. The Rosenberg suit challenged this procedure claiming that a separate determination is needed for medical assistance in both denials and discontinuances.

III. PROGRAM IMPLICATIONS

The settlement in the Rosenberg case will require changes in future procedures for handling the determination of eligibility for medical coverage where an application for cash public assistance is denied or where a cash public assistance case is to be closed, and will require certain steps to be taken to advise past applicants for and recipients of public assistance that they may be entitled to relief because their eligibility for Medicaid was not determined separately from their eligibility for public assistance. Starting on February 18, 1982, any public assistance applicant whose application has been denied is entitled to have their eligibility for medical assistance coverage determined, independent of the decision made on the public assistance application and is entitled to notice of the determination made regarding medical assistance coverage. Similarly, any recipient of public assistance whose public assistance case is to be closed after February 18, 1982, will be entitled to continue to receive medical assistance coverage until found ineligible for future medical assistance coverage and until they are given advance notice of the proposed termination of medical assistance. Specific instructions regarding the handling of medical assistance coverage for future public assistance applicants and recipients are contained in Section IV. of this release.

Certain individuals and families who have either been denied in the past when they applied for public assistance or who have had benefits under the public assistance program cut off, are entitled to relief under the medical assistance program for any bills they incurred for medical expenses which they would not have incurred if their eligibility for medical assistance had been decided independently of their eligibility for cash public assistance. The method for implementing this relief is contained in Section IV. of this release.

Department Regulations 360.1 and 360.18(b) are both being revised to reflect this consent judgment, i.e. the application for cash public assistance becomes a separate application for medical assistance where the application for assistance does not result in the automatic provision of medical assistance coverage.

IV. REQUIRED ACTION

As a result of the Rosenberg consent judgment certain retrospective and prospective actions are required as follows:

A. Prospective

Effective no later than February 18, 1982, a separate Medicaid determination must be made when an ADC or HR cash case is denied or closed. Where the reason for denying or closing the cash public assistance case is also a valid reason for closing or denying Medicaid coverage, a single notice may be sent concerning the action taken on both cash public assistance and Medicaid. The notice must separately and clearly explain the reason for closing or denying both the PA and MA case, along with the client's right to aid continuing and a fair hearing. The reasons specified below are reasons for denying or terminating both the PA case and the MA case.

1) Client Status

- a. Client is currently in receipt of medical assistance under another program.
- * ~~b. Client is an alien, not permanently residing in the U.S., or not residing in the U.S. under Color of Law.~~
- c. Single individuals, childless couples, and parents in intact HR families, between 21 and 64, not aged, blind or disabled, and not financially eligible for home relief.
- d. The agency cannot locate the client.

2) Procedural Requirements

- a. Failure to comply with procedural requirements which are also required for MA (eg: failure to apply for an income/resource benefit, other than cash assistance, for which an individual is potentially eligible).
- b. Failure to appear for an interview appointment with agency, provided that the client has been notified that the interview is for both PA and MA.

* CANCELLED PARA. IV A. 1.b)

- c. Failure to furnish required information.
- d. Refusal to obtain a Social Security number.

When the same listed reason is used to deny the MA case as well as the PA case, the required notice (See Attachment 1) must separately and clearly explain the reason for denying both the PA and MA case, along with the client's right to a fair hearing. Likewise, when an active PA case is being closed for the same reason as the MA case, the notice to be used is the NOTICE OF INTENT contained in 81 ADM-55, "Implementation of the Applicable Provisions of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35)," and must separately and clearly explain the reason for closing both the MA and PA case, along with the client's right to a fair hearing.

B. Required Action for Future Applicants

1. Future applicants are those individuals who apply for cash public assistance benefits, (including ADC/FC), except for applicants for Emergency Assistance to Adults (EAA) and Emergency Assistance to Families (EAF) and whose applications are either denied or not acted upon until after 2/18/82 or who otherwise do not receive MA as a result of filing the PA application after 2/18/82.
2. When the application or determination for PA made after 2/18/82 does not result in the automatic provision of MA, eligibility for medical assistance shall be determined independent of any determination of ineligibility for public assistance unless the applicant knowingly indicates in writing that (s)he does not want medical assistance. Where the reason for denying the public assistance application is also a valid reason for denying medical assistance a determination denying benefits under both programs should be made. (The list of those reasons for dual denials is given above under section IV, A).
 - a. All future applicants who are determined ineligible for medical assistance are entitled to adequate notice of that determination (Attachment 1). If cash public assistance and medical assistance are being denied for the same reason (Section IV, A, above), a single notice may be used but must give the reasons for the action taken on the medical assistance coverage as well as the action taken on the cash public assistance grant. The right to a fair hearing on either or both programs must also be included. The notice (Attachment 1) is mandated and should be reproduced, but the contents should not be modified. Attachment 1, however, does not replace or supersede DSS 3152 Action Taken on Your Food Stamp Case.

- b. MA eligibility determinations shall be made within a 30 day time period, starting at the date that the PA application is denied.
 - c. For PA applications not receiving action in a timely manner, MA eligibility determinations shall be made within 30 days from the date action should have been taken on the PA application.
 - d. Time limits may be extended, on an individual basis only, as provided by state regulations. (Department Regulation 360.39).
3. An application for public assistance shall be treated as an application for medical assistance and shall be deemed filed on the date the application for public assistance is made. However, for purposes of computing the time within which a determination on medical assistance eligibility must be made, 2 (b) (c) and (d) above apply.
 4. The WMS common application DSS-2921 shall be utilized to register a case in WMS and the workbook shall be used to capture data necessary for the determination of PA and MA eligibility, with the exception of New York City where WMS is not yet implemented. The New York City application shall be subject to the same condition of capturing this data for the determination of both PA and MA. For detailed WMS procedures see section IV K of this release.
 5. The failure of an applicant to provide the necessary information to the determination of MA eligibility, shall not be reason to deny or delay application for PA, except as provided for in joint closings or denials as described in Section IV A.
 6. If an application for PA is denied, but additional information is required to determine MA eligibility, the applicant shall be notified and given an opportunity to provide the additional information.
 7. Applicants shall not be required to provide duplicate documentation necessary for the MA eligibility process or verification of information recorded by the agency prior to the denial of the PA application.
- C. Required Action for Current or Future Recipients

Current or future recipients are those individuals who currently receive or will receive cash public assistance benefits and who may be suspended or terminated on or after February 18, 1982.

1. Medical assistance shall be continued for recipients whose PA case is terminated or suspended until one of the following occurs:

- a. A redetermination of MA eligibility is performed independent of any determination of ineligibility for PA. This redetermination shall be performed by the end of the calendar month following the month of PA determination.
- b. In determinations to suspend or terminate PA, an advance notice of the action to be taken must be provided, including the right to a fair hearing, and a description of the circumstances under which aid will continue pending a hearing. Where the reason to suspend or terminate PA is also a proper basis for the suspension, reduction or termination of MA or where PA is being terminated or suspended but MA continued, a single notice may be sent, provided it separately advises the recipient of the actions being taken regarding MA, including the reason for the action and the regulation supporting the action. This notice, NOTICE OF INTENT is provided as an attachment to 81 ADM 55, "Implementation of the Applicable Provisions of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35)". It should be noted that the procedures for handling a Public Assistance/Food Stamp application has not changed and can be found in Section III, E of the New York State Food Stamp Manual (NYSFSM).
- c. If the reason to suspend or terminate PA is not a proper basis for the termination of MA and the district thereafter determines that the recipient is ineligible for continued Medicaid benefits, the district must send separate adequate advance notice prior to the termination of Medicaid eligibility.

D. Identification of Past Applicants

1. Past applicants are individuals who:
 - a. Applied for HR or ADC (excepting EAF, and EAA) and had their applications denied between October 30, 1976 and February 18, 1982. When past applicants for cash public assistance were denied, their eligibility under the medical assistance program was not separately determined. Past applicants are now entitled to notice (attachments 3 and 4) that certain medical bills incurred after cash public assistance was denied will now be paid for if they can show that they meet the following requirements:
 - b. Establish by documentary proof or other reasonable means that may be available, considering the

passage of time, that they applied for cash public assistance between October 30, 1976 and February 18, 1982 and,

- c. Were denied cash public assistance benefits,
- d. Submit documentary proof of having incurred reimbursable bills, including proof of payment where reimbursement is sought for a paid bill,
- e. Can establish eligibility for medical assistance coverage at or about the time the medical expenses were incurred, using present medical assistance eligibility standards. The applicant must establish eligibility using such proof or verification that can reasonably be provided given the passage of time since the bill was incurred.
- f. Had not, prior to the date of the reimbursable bill, separately applied for and been denied medical assistance, and had been provided adequate notice of MA denial and fair hearing rights.

E. Identification of Past Recipients

Past recipients are those who affirm that they were recipients of cash public assistance and had cash public assistance benefits terminated between October 30, 1976 and February 18, 1982, unless the local district can prove that the individual was not a recipient between October 30, 1976 and February 18, 1982 by documentary proof.

To obtain reimbursement for medical bills, these past recipients must meet all of the following criteria:

1. Submit documentary proof of reimbursable bills, including proof of payment for paid bills
2. Not have been ineligible for medical assistance at the time the medical expense was incurred, applying present Medicaid assistance standards. Past recipients do not have to establish their eligibility for MA during the applicable time periods. They are eligible unless the agency can establish that they were ineligible. The agency may ask the past recipient to supply information about eligibility during the applicable time periods provided the documentation or verification is in the past recipient's possession. A past recipient cannot be asked to obtain documentation or verification that is not in his or her possession. Thus, to deny reimbursement for medical bills during the applicable time periods, local districts are required to affirmatively prove ineligibility for medical assistance.

3. Not have separately applied for and been denied medical assistance, and received adequate notice of MA denial and fair hearing rights for medical assistance coverage prior to the date of the incurred bill, but after PA was terminated.

Past recipients do not have to establish eligibility for medical assistance during the applicable time periods, but shall provide available relevant information when requested. To deny reimbursement for medical bills during the applicable time periods, local districts are required to affirmatively prove ineligibility for medical assistance.

F. Reimbursement Procedures

The local district is responsible for performing the following procedures:

1. Notification shall be provided to past applicants and recipients pursuant to Section IV, I of this Administrative Directive.
2. Determinations of eligibility for payment or reimbursement shall be approved or disapproved within 90 days of submission of medical bills by the applicant or recipient.
3. Issuance of written notices within 90 days of receipt of medical bills to individuals who apply for payment of medical bills regarding the disposition of these bills. These notices should be developed by the local district. However, such notices must include the following:
 - a. Action to be taken.
 - b. Reasons for the action.
 - c. Right to a fair hearing.

Local districts have the option of processing claims and issuing payments for direct reimbursement to Rosenberg class recipients or of having the State Department of Social Services process claims and issue the required payments.

G. Required actions for local districts that elect to process claims and issue payment for direct reimbursement to Rosenberg class recipients.

Medical expenses for care, services and supplies covered under the Medical Assistance Program at the time rendered, shall be reimbursable under certain conditions:

1. Conditions of Reimbursement Period

- a. For past PA applicants, paid or unpaid medical bills incurred during the period 3 months prior to the date of the PA application and ending with the date notice is provided, as in Section IV, I of this ADM.
 - b. For past PA recipients, paid or unpaid medical bills incurred between the termination of cash public assistance and the date notice is provided, as in Section IV, I of this ADM.
2. Conditions for payment of reimbursable bills:
- a. Payment shall be made at the rate provided by MA at the time the bills were incurred.
 - b. For paid bills, payment will be made to the applicant, recipient or individual who made payment on behalf of the applicant or recipient.
 - c. Unpaid bills will be reimbursed to the individual or organization that provided care, services or supplies for which reimbursement is sought.
 - d. There is no requirement that care, services or supplies must have been obtained from a provider enrolled in the MA program at the time bills were incurred or paid at the time reimbursement is sought. However, all providers must have been lawfully permitted to provide such care, services, and supplies, at the time it was rendered. Only care, services, and supplies covered under MA at the time they were incurred are reimbursable.
 - e. As is currently the case, Medicaid reimbursement is not available until such time as any existing third party health insurance is exhausted and any potentially available third party health insurance has been explored.
3. The local district must process the bills submitted and determine the amount approved for payment in the following manner:
- a. Verify that the applicant/recipient is eligible for payment or reimbursement of bills by insuring that the dates of service fall within the appropriate period.
 - b. Verify that the type of service is covered by Medicaid.
 - c. Determine the type of claim (e.g. physician, dental, clinic, etc.).
 - d. For Fee-for-Service bills (includes physician, dental, podiatry, psychologist, therapist, laboratory, durable medical equipment, pharmacy, ophthalmic, hearing aid

dealer and nurse), the appropriate procedures must be determined from the description of service. For prescription drug bills, information must be obtained on the name of the drug, the manufacturer's name, the strength and quantity dispensed. If the client is unable to provide this information, the agency shall make every reasonable effort to obtain the necessary documentation. Bills will be processed for payment at the rate or fee provided by MA at the time the bill was incurred.

- e. For rate based bills for Home Health Care, Personal Care Services, Long Term Home Health Care, Transportation, Inpatient, Clinic, Residential Health Care Facility and Child Care Agency services, the rate or fee for the provider must be determined. Bills will be approved for payment at the amount of the provider's Medicaid rate in effect at the time the bill was incurred.

H. Required Action for local districts that elect to have the State DSS process claims and issue payment to Rosenberg class recipients.

Local districts electing to have the State DSS process claims and issue payments to eligible class members must notify the appropriate contact person in the Bureau of Local Financial Operations by no later than March 15, 1982 of this election.

The local district must forward, within 90 days of the date of submission of medical bills by the applicant or recipient, the following information:

1. A completed Payment Request Form (See Attachment 2) for each eligible recipient.
2. Copies of all eligible bills for which payment or reimbursement is requested must be attached to Payment Request Form.
3. Where reimbursement is sought, include documentation (copies of receipts or cancelled checks) of any payments made by the applicant, recipient or individual who made payment on behalf of the applicant or recipient.

The above information should be submitted to the following address:

New York State Department of Social Services
P.O. Box 1935
Albany, New York 12201
Attention: Rosenberg Case

The Department shall process all eligible bills for which reimbursement is requested within 30 days of receipt of the approved payment request from the local district.

I. Notification of Past Applicants and Recipients

1. Individual notices

All past applicants and past recipients, from October 30, 1976 through February 18, 1982 entitled to relief as specified in this release and as previously specified in the Dear Commissioner letter dated December 10, 1981, where segregated and reasonably identifiable records exist shall be sent the attached individual notice of their rights (Attachment 3) under this action, by March 1, 1982, if names are available on EDP Systems. If a manual search of records is necessary these notices must be sent by April 15, 1982. Where there is Spanish readership, the Spanish version of the notice (Attachment 3a) shall also be sent.

2. Affidavits specifying missing or unidentifiable records

a. When segregated and reasonably identifiable records do not exist for specific time periods or type cases to provide for individual mailings to past applicants and recipients:

i. Local Commissioners shall provide to plaintiffs' attorneys, affidavits specifying the missing or unidentifiable records.

ii. Based on these affidavits, Plaintiffs' attorneys will either

(a) Agree that individual mailings are not required, but that notice (attachment 4) be provided as a stuffer with all PA checks for one regular check issue. This shall occur no later than April 2, 1982.

(b) Apply to the court for a determination of whether individual notices should be sent.

iii. By January 15, 1982, all affidavits must be received by Counsels Office NYSDSS, 40 North Pearl St., Albany.

iv. Local districts requiring technical assistance in preparing these affidavits should have their counsel contact:

Lewis Nestle, Esq.
Office of Counsel
40 North Pearl Street
Albany, New York 12243

3. Public notices

Local districts shall also post the attached (Attachment 4) notice at all Medical Assistance centers, Income Maintenance Centers, Food Stamp Centers and shall request the posting of these notices at Social Security Offices, Senior Citizen Centers, Post Offices and Welfare Organizations. Posted notices shall be a minimum of 12" by 14".

A notice (Attachment 4) shall be placed at least 3 times between February 15, 1982 and March 15, 1982 in local newspapers of county-wide distribution, with the newspapers selected for maximum readership of the notice. The published notices shall be no smaller than 4" by 6".

Where Spanish language notices are provided, the Spanish version of the notice (attachment 4a) shall also be used.

Notice 4 and 4a provides for local social services districts to mail an application to potential Rosenberg class members, along with appropriate instructions for submission to the agency. Social services districts must submit the proposed instructions and application for benefits prior to use to:

Lewis Nestle, Esq.
Office of Counsel
40 North Pearl Street
Albany, New York 12243

4. Time limits for response

- a. Past applicants and recipients who receive an actual notice and apply for payment of bills within 105 days after the last date of mailing for individual notices shall be considered for processing of payment.
- b. Past applicants or recipients who do not receive individual notice may apply for reimbursement for a period of one year after the last date of mailing of individual notices or publication of the notices, whichever is later.
- c. Past applicants or recipients who do not receive notice and do not apply for reimbursement within one year after the last date of mailing of individual notices or publication of the notices cannot be processed through the procedures in this administrative directive. Such individuals should be given a notice of denial and should be advised of

their right to a fair hearing or their right to pursue state court remedies.

J. Reporting Requirements

1. Within 60 days after the date of the last mailings, posting and publication of the notices, local districts shall submit to NYSDSS Office of Counsel:
 - a. Dates of mailing individual notices
 - b. Number of pieces mailed
 - c. Dates of publication of notices
 - d. Names of Newspapers where published
 - e. Copies of the newspaper notices
 - f. Dates notices were posted
 - g. Locations and number of postings
2. For the periods 12/1/81 to 2/28/82, 3/1/82 to 5/30/82, 6/1/82 to 8/31/82, 9/1/82 to 11/30/82 and 12/1/82 to 2/28/83, local social service districts shall submit the following information to Lewis Nestle, Esq., Office of Counsel. Counsel's office will provide this information to the plaintiff's attorneys.
 - a. The number of reimbursement requests by clients
 - b. The number of individuals for whom medical bills were paid
 - c. A breakdown of the reasons bills were not paid after receipt of a request
3. The names and addresses of individuals requesting reimbursement shall be maintained by the local districts for submission to plaintiff's counsel upon request.
4. Any legal questions should be directed to Lewis Nestle, Esq., by writing or calling toll free at 1-800-342-3715, Ext. 4-7692.

K. WMS Instructions

It is not necessary to establish a case on WMS for past PA applicants or recipients. Therefore, the following instructions apply only to future applicants/recipients where an MA determination is indicated (i.e., the denial/closing is for reasons other than those listed in Section IV, A. of this directive.)

For those cases that have been denied PA, a photocopy of the application will be needed to register and clear the applicants for the MA determination.

In those instances where a recipient is closed on PA, an MA case should be opened to assure continuance of MA eligibility until a redetermination can be made. More detailed procedures will be issued as Temporary Replacement Page III-A-2.1 to the Forms and Procedures Manual.

L. Claiming Procedures

1. Administrative Claiming

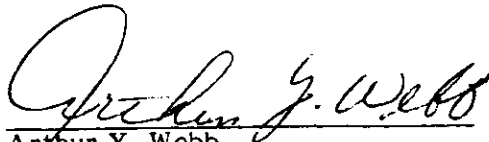
Claiming for the Administrative expenses associated with eligibility recomputations for Rosenberg class members should be considered part of the normal Medical Assistance Administrative expenses. These expenses are reported monthly on the Schedule D-4 (DSS-2347 b) as a function 4 activity. (Calculation of Medical Assistance Eligibility Determination/Authorization/Payment/Cost/Shares).

2. Direct Payment Claiming

Claiming Medical Assistance under Title XIX should be reported in the normal manner by item expense on the Schedule E (DSS-157). Expenses for direct reimbursement to eligible class members should be considered the same as vendor payments for claiming purposes.

V. Effective Date

The effective date of this release is January 15, 1982, except for the provisions of this release which are retroactive.



Arthur Y. Webb
Executive Deputy Commissioner

(Attachment 1)

County Case # Name of Agency; Center or District Office

Notice Date Effective Date

Date of Birth Sex Soc. Sec. # Address

Case Name (L, F, MI)

(NOTICE OF DENIAL OF PUBLIC ASSISTANCE APPLICATION AND NOTICE OF STATUS OF MEDICAL ASSISTANCE APPLICATION)

Street

City State Zip

Public Assistance - Your application for Public Assistance dated _____ has been Denied because:

This denial is being made pursuant to:

Medical Assistance - The following action has been taken on your application for medical assistance:

- () Your application for medical assistance has been accepted. You will be issued a medical assistance authorization entitling you to full services. The attached letter will clarify your Medicaid coverage.
- () You have surplus income of \$ _____ monthly. You can receive medical assistance coverage for most bills incurred or paid in any month in which your bills equal or exceed \$ _____. You can also receive coverage for hospital bills (if you are admitted as an inpatient to the hospital), prosthetic appliances or dentures if the bill is greater than six times the amount of your surplus (\$ _____). The attached letter will explain your eligibility under the surplus income procedures.
- () We do not have enough information to decide your eligibility for medical assistance. Please contact us at _____ so we can tell you the information we need.
- () Your application for medical assistance is being reviewed. We'll send you our decision within thirty days.
- () Your application for medical assistance has been denied because:

This denial is being made pursuant to:

CONTINUE READING THE OTHER SIDE FOR OTHER IMPORTANT INFORMATION

Food Stamps - The following action has been taken on your application for Food Stamps:

- () Your application for food stamps has been accepted. You will receive \$ _____ each month in benefits.
- () Your application for food stamps has been denied for the following reasons:

This denial is made pursuant to:

Social Services Information -

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 you can. A conference may clear up any questions you have about this action. You may ask for a conference by calling us at _____. This number is used only for asking for a conference. It is not the way you request a fair hearing, and if you ask for one it does not affect your right to a fair hearing. Read the information below for fair hearing information.

RIGHT TO A FAIR HEARING IF YOU DON'T AGREE WITH THESE ACTIONS

If you think the actions we have taken on your application for cash public assistance, medical assistance or food stamps, are in error, you may request a State fair hearing in the following way:

- (1) Call for a hearing at _____
- (2) Write for a hearing to: Fair Hearings, P. O. Box 1930, Albany New York, 12201. If you write send one copy of this notice with the letter.

Your request for a fair hearing must be made within 60 days of the date of this notice, except that you have 90 days to request a hearing about your food stamps.

If you request a fair hearing, a notice will be sent to you telling you where the hearing will be. You can have an attorney or other person come to represent you at the hearing or you may come by yourself. At the hearing, you or your representative may present written or oral evidence to show why the action taken is wrong. You or your representative may bring witnesses and you may question anyone who appears at the hearing to present evidence against you. You should bring to the hearing any papers, such as paystubs, rent receipts, medical bills, heating bills, childcare expenses, etc. that may be helpful to your case.

If you need legal assistance for your conference or fair hearing, you may be able to obtain it free if you cannot afford a lawyer by contacting:

Signature of Worker: _____ Telephone No: _____
Date: _____

READ THIS NOTICE IMMEDIATELY: MEDICAID MAY OWE YOU MONEY

IF YOU OR A MEMBER OF YOUR HOUSEHOLD EVER APPLIED FOR PUBLIC ASSISTANCE AND WERE DENIED OR IF YOU EVER RECEIVED PUBLIC ASSISTANCE AND YOUR GRANT WAS STOPPED (EVEN FOR A SHORT TIME), MEDICAID MAY HAVE TO PAY FOR PAST MEDICAL BILLS OR MAY HAVE TO REPAY YOU FOR MONEY YOU SPENT ON MEDICAL CARE FOR YOURSELF OR A MEMBER OF YOUR FAMILY. MEDICAL CARE INCLUDES BILLS FOR HOSPITALS, DOCTORS, MEDICINE, EYEGASSES AND OTHER MEDICAL EXPENSES. TO SEE IF YOU ARE ELIGIBLE, CHECK TO SEE IF YOU CAN ANSWER "YES" TO ALL THE QUESTIONS IN BOX A OR ALL THE QUESTIONS IN BOX B BELOW.

BOX A	BOX B
<ol style="list-style-type: none">1. Did you or any member of your household apply for public assistance at any time between October 30, 1976 and February 18, 1982?2. Was the application denied?3. Did you or a household member have medical expenses after the application was denied or in the three months just before the date you applied for public assistance?	<ol style="list-style-type: none">1. Did you or any member of your household lose public assistance coverage for any length of time between October 30, 1976 and February 18, 1982?2. Did you pay for or do you still owe money for medical assistance services that you or a household member received after your public assistance was stopped?

IF YOU ANSWERED "YES" TO THE THREE QUESTIONS IN BOX A OR IF YOU ANSWERED "YES" TO THE TWO QUESTIONS IN BOX B, FILL OUT THE FORM BELOW AND MAIL IT IN. IF YOU ARE FOUND ELIGIBLE FOR MEDICAID AT THE TIME YOU RECEIVED THE MEDICAL SERVICES, ALL OR PART OF YOUR MEDICAL BILL WILL BE PAID FOR. IF YOU ALREADY PAID FOR THE MEDICAL SERVICES, YOU WILL BE REPAID FOR SOME OR ALL OF THE MONEY YOU SPENT. IF YOU HAVE TROUBLE IN ANSWERING THE QUESTIONS IN BOX A OR BOX B, YOU MAY CALL () FOR HELP.

YOU CANNOT USE THIS FORM TO OBTAIN MEDICAID COVERAGE FOR PRESENT OR FUTURE BILLS. IF YOU ARE NOW WITHOUT MEDICAID, YOU MAY WANT TO APPLY FOR IT. YOU MAY BE ELIGIBLE FOR MEDICAID EVEN THOUGH YOU ARE NOT ELIGIBLE FOR PUBLIC ASSISTANCE.

PAYMENT IS NOT AVAILABLE FOR BILLS BEFORE OCTOBER 30, 1976. IF YOU HAVE SUCH BILLS, CHECK WITH A LEGAL SERVICES OFFICE TO SEE WHETHER YOU SHOULD APPLY FOR REPAYMENT.

HEARING RIGHTS

If you are not contacted and given an appointment to come in to your Medicaid office within fifteen days after you mail in the form below, you should ask for a fair hearing by calling _____ or by writing to Fair Hearings, 40 North Pearl Street, Albany, New York. Whenever you speak or write to Medicaid or Fair Hearings, you should tell the worker that you want payment of past medical bills as provided for in the Rosenberg case.

REQUEST FOR ROSENBERG RELIEF

I want my eligibility for payment of past medical bills determined.

Check one of the following, or if you were able to answer all questions in both Box A and Box B, check both of the following:

- I was able to answer "yes" to the three questions in Box A.
- I was able to answer "yes" to the two questions in Box B.

My Name is _____

My address is _____

My telephone number is _____

The welfare center that handled my case is _____

DO NOT SEND IN MEDICAL BILLS NOW. YOU WILL BE SENT FURTHER INSTRUCTIONS ABOUT SUBMITTING BILLS. YOU SHOULD KEEP A COPY OF THIS NOTICE SO THAT YOU CAN SHOW IT LATER IF NECESSARY.

SEND THIS FORM TO:

FAVOR DE LEER ESTE AVISO INMEDIATAMENTE: "MEDICAID" LE PUEDE DEBER DINERO A USTED.

SI USTED O UN MIEMBRO DE SU HOGAR HA SOLICITADO PARA ASISTENCIA PUBLICA Y SE LE DENEGO LA AYUDA, O SI USTED RECIBIA ASISTENCIA PUBLICA Y LA MISMA FUE SUSPENDIDA (AUN POR POCO TIEMPO), EL PROGRAMA DE "MEDICAID" QUIZAS TENGA QUE PAGAR POR SUS CUENTAS MEDICAS O REEMBOLSARLE EL DINERO QUE USTED PAGO POR GASTOS MEDICOS, YA SEAN GASTOS PROPIOS O DE UN MIEMBRO DE SU FAMILIA. LOS GASTOS MEDICOS PUEDEN INCLUIR GASTOS DE HOSPITAL, MEDICO, MEDICINAS, ESPEJUELOS Y OTROS GASTOS. USTED PUEDE SER ELEGIBLE SI CONTESTA "SI" A TODAS LAS PREGUNTAS EN EL ENCASILLADO A, O TODAS LAS PREGUNTAS EN EL ENCASILLADO B.

ENCASILLADO <u>A</u>	ENCASILLADO <u>B</u>
<ol style="list-style-type: none">1. ¿Ha solicitado usted u otro miembro de su hogar para asistencia pública durante cualquier tiempo entre octubre 30 de 1976 y febrero 18 de 1982?2. ¿Fue denegada su solicitud?3. ¿Ha tenido usted, u otro miembro de su hogar, gastos médicos después de ser denegada su solicitud, o durante los tres meses antes de solicitar la asistencia pública?	<ol style="list-style-type: none">1. ¿Ha perdido usted u otro miembro de su hogar los beneficios de asistencia pública durante cualquier tiempo entre octubre 30 de 1976 y febrero 18 de 1982?2. ¿Ha pagado usted, o debe dinero por servicios médicos rendidos después de ser suspendida su asistencia?

SI USTED CONTESTO "SI" A LAS TRES PREGUNTAS EN EL ENCASILLADO A O SI USTED CONTESTO "SI" A LAS DOS PREGUNTAS EN EL ENCASILLADO B, LLENE EL FORMULARIO INCLUIDO MAS ABAJO Y ENVIELO. SI SE DETERMINA QUE USTED ERA ELEGIBLE PARA "MEDICAID" DURANTE EL TIEMPO QUE USTED RECIBIO LOS SERVICIOS MEDICOS, SE PAGARA PARTE O TODA LA CANTIDAD DE LA FACTURA MEDICA. SI USTED YA PAGO POR ESTOS SERVICIOS, SE LE REEMBOLSARA PARTE, O EL TOTAL, DE LA CANTIDAD QUE USTED PAGO. SI USTED TIENE DIFICULTAD CONTESTANDO LAS PREGUNTAS EN LOS ENCASILLADOS A O B, USTED PUEDE LLAMAR AL () PARA ASISTENCIA.

USTED NO PUEDE UTILIZAR ESTE FORMULARIO PARA RECIBIR BENEFICIOS DE MEDICAID O POR GASTOS EN LA ACTUALIDAD O EN EL FUTURO. SI USTED ESTA SIN MEDICAID, USTED QUIZAS QUIERA SOLICITARLO. USTED PUEDE SER ELEGIBLE PARA ASISTENCIA MEDICA ("MEDICAID") AUN NO CALIFIQUE PARA ASISTENCIA PUBLICA.

NO SE PAGARAN FACTURAS POR SERVICIOS MEDICOS QUE HAIGA RECIBIDO ANTES DE OCTUBRE 30 DE 1976. SI USTED TIENE TALES FACTURAS, CONSULTE CON LA OFICINA DE SERVICIOS LEGALES PARA DETERMINAR SI USTED DEBE SOLICITAR UN REEMBOLSO.

DERECHO A UNA AUDIENCIA IMPARCIAL

Si a los quince días de usted haber enviado este formulario, nuestra oficina no se pone en contacto con usted para ofrecerle una cita con la oficina de "medicaid", usted debe pedir una audiencia imparcial llamando al () o escribiendo a "Fair Hearings" 40 North Pearl Street, Albany, New York. Cuando usted hable o escriba a "medicaid", o la oficina de Audiencias Imparciales (Fair Hearings), usted debe indicarle a los trabajadores que usted está solicitando pagos por gastos médicos según el caso "Rosenberg".

PETICION PARA COMPENSACION BAJO EL CASO ROSENBERG

Quiero que se determine mi elegibilidad para recibir pago por gastos médicos.

Seleccióne una de las siguientes, o ambas, si usted contesto "sí" a todas las preguntas en los encasillados A y B

() Yo contesté "sí" a las tres preguntas en el encasillado A.

() Yo contesté "sí" a las dos preguntas en el encasillado B.

Mi nombre es _____

Mi Dirección es _____

Mi número de teléfono es _____

La oficina de Asistencia Pública que se encargó de mi caso fue _____

NÓ ENVIE FACTURAS POR GASTOS MEDICOS AHORA, A USTED SE LE ENVIARAN INSTRUCCIONES DE COMO SOMETER PRUEBA DE ESTAS. USTED DEBE MANTENER COPIA DE ESTE AVISO PARA PODER PRESENTARLO EN EL FUTURO SI ES NECESARIO.

ENVIE ÉSTE FORMULARIO A:

Welfare Applicants and Recipients

MEDICAID MAY OWE YOU MONEY FOR PAST MEDICAL BILLS!

Because of a lawsuit, Medicaid has to pay some people's past medical bills. Medicaid must also repay some people for money they spent on medical care.

YOU MAY BE ELIGIBLE FOR PAYMENT IF YOU CAN ANSWER "YES" TO THE QUESTIONS IN EITHER BOX A OR BOX B.

BOX A

1. Did you or a household member apply for welfare at any time between October 30, 1976 and February 18, 1982?
2. Was the application denied?
3. Did you or a household member have medical expenses after your application was denied, or in the 3 months just before you applied for public assistance?

BOX B

1. Did you or a household member lose welfare for any length of time between October 30, 1976 and February 18, 1982?
2. Did you pay for or do you still owe money for medical services that you or a household member received after your public assistance stopped?

If you said "yes" to the questions in Box A or B ask us for an application form. Don't delay because you must file an application within the next 15 weeks. Write to us, or visit us in person.

AGENCY NAME ADDRESS TELEPHONE NUMBER

When you contact us, give us your name, address and tell us you want a Rosenberg application. It will help if you can tell us which boxes you answered yes to.

This notice is for past medical bills only. For future medical bills you may want to apply for Medicaid if you are not now covered. You may be eligible for Medicaid even if you are not eligible for welfare.

DO NOT MAIL IN BILLS. HOLD THEM UNTIL YOU GET AN APPLICATION

Solicitantes y recipientes de Asistencia Pública ("Welfare")

"MEDICAID" LE PUEDE DEBER DINERO A USTED POR GASTOS MEDICOS PREVIOS!

Debido a una acción legal "medicaid" tendrá que pagar las facturas médicas de algunas personas. "Medicaid" también tendrá que reembolsarle dinero a algunas personas que hayan pagado por servicios médicos.

USTED PUEDE SER ELEGIBLE SI CONTESTA "SI" A TODAS LAS PREGUNTAS EN EL ENCASILLADO A O EL ENCASILLADO B.

ENCASILLADO A

1. ¿Ha solicitado usted u otro miembro de su hogar para asistencia pública durante cualquier tiempo entre octubre 30 de 1976 y febrero 18 de 1982?
2. ¿Fue denegada su solicitud?
3. ¿Ha tenido usted, u otro miembro de su hogar, gastos médicos después de ser denegada su solicitud, o tres meses antes de solicitar?

ENCASILLADO B

1. ¿Ha perdido usted u otro miembro de su hogar los beneficios de asistencia pública durante cualquier tiempo entre octubre 30 de 1976 y febrero 18 de 1982?
2. ¿Ha pagado usted, o debe dinero por servicios médicos rendidos después de ser suspendida su asistencia?

Si usted contesto "sí" a las preguntas en el encasillado A o B, favor de pedirnos una solicitud. No demore, porque usted tiene que someter la solicitud dentro de las proximas 15 semanas. Escriba, llame o visitenos.

NOMBRE DE LA AGENCIA

DIRECCION

NUMERO DE TELEFONO

Cuando usted nos llame, de su nombre y dirección y diga que quiere una solicitud Rosenberg. Nos ayudaría si nos puede decir cuales de las preguntas contesto afirmativamente.

Este aviso es para las personas que hayan recibido servicios. Las personas que tendrán gastos en el futuro tienen que solicitar para "medicaid" si lo desean. Usted puede ser elegible para "medicaid" aunque no cualifique para asistencia pública (Welfare).

NO ENVIE FACTURAS O CUENTAS: GUARDELAS HASTA QUE OBTENGA LA SOLICITUD.

ROSENBERG TRANSMITTAL FORM

ATTACHMENT 2

LOCAL DISTRICT: _____

RECIPIENT NAME: _____

RECIPIENT ADDRESS: _____

Medicaid Identification Number: _____

NAME & ADDRESS OF SERVICE PROVIDER	DESCRIPTION OF SERVICE PROVIDED (For prescription drugs, show name, strength and quantity)	DATE OF SERV. (MO/DAY/YR)	TOTAL BILL	AMOUNT PAID (or balance due after insurance payment)	NAME & ADDRESS OF PAYOR IF OTHER THAN RECIPIENT

I certify that the above-named recipient is eligible for Medical Assistance benefits as a member of the Rosenberg v. Blum class.

DATE COMPLETED _____

X
SIGNATURE OF LOCAL DISTRICT ELIGIBILITY WORKER _____