New York
Medicaid Choice
New York State's Medicaid managed care enrollment program

1-888-401-6582
Ask ▪ Choose ▪ Enroll

P.O. Box 5009, New York, NY 10274-5009

[Date]

<Barcode> <Letter Code>
<In Care Of>
<Name>
<Address>
<City>, <State>, <Zip>\

Important Notice About Your Enrollment in Managed Long Term Care

Dear [Consumer Name]: [CIN]

New York State changed **how nursing home benefits will be covered for people in Medicaid Managed Long Term Care Partial Capitation Plans.** MLTC Partial Capitation plans will only pay for three (3) months of long-term nursing home care. Because you have been in a long-term nursing home stay for more than three months you will be disenrolled from **[Old Health Plan]** on **[Plan Disenrollment Effective Date]**.

This does not change your eligibility for Medicaid. You still qualify for Medicaid coverage of nursing home care because you have been determined financially eligible for such care and services. After **[Plan Disenrollment Effective Date]**, your nursing home care will be paid for through regular Medicaid.

Who determines that I am in a long-term nursing home stay?
A decision that a nursing home stay will be long-term is a decision made between you, your doctor, and your nursing home. It means that based on an assessment of your medical needs, you are not expected to return home or to another community setting. A long-term nursing home stay decision does not prevent you from changing your mind and returning to the community if it is safe for you to do so.

What happens next

- You will receive your nursing home care under regular Medicaid.
- If you have been paying some of your monthly income toward the cost of your nursing home care, you must continue to pay the income directly to the nursing home where you are residing.

Questions?
If you have questions about this letter, you can call **[Old Health Plan]** at **[Medical Plan Phone].**

You can also call us, **New York Medicaid Choice**, if you need help. You can call us at **1-888-401-6582** (TTY: 1-888-329-1541). You can call Monday - Friday, from 8:30 a.m. – 8:00 p.m. and Saturday, from 10:00 a.m. – 6:00 p.m. Our counselors can help in all languages.

Thank you,

New York Medicaid Choice.

Please turn this page

Information about The Independent Consumer Advocacy Network

The Independent Consumer Advocacy Network (ICAN) is the ombudsman program for health plan members. ICAN can answer your questions and give you free, independent advice about your coverage, complaints, and appeals' options. To learn more about ICAN, go to www.icannys.org, or call 1-844-614-8800 between the hours of 8am to 6pm. TTY: 711. All services are free.

(FH#299 A)

This action has been taken in accordance with Public Health Law Section 4403-f. If you would like to talk to someone about this decision, you may have a conference to review these actions. If you believe this decision is wrong, you may ask for a State fair hearing. Please read the back of this notice to find out how to arrange a conference and/or a fair hearing.

FH#299A-NYC-0613

NOTICE OF DISENROLLMENT FROM <MLTC PLAN NAME>

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 New York Medicaid Choice at 1-888-401-6582, TTY: 1-888-329-1541. You can also send a written request by fax: 917-228-8899, or mail it to: Conference Unit, New York Medicaid Choice, P.O. Box 5016, New York, NY 10274. These phone numbers and address are only to ask 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, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. 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:** Statewide Toll Free 1-800-342-3334. Please have this notice with you when you call.

2. **FAX:** Fax a copy of all the pages of this notice to (518) 473-6735.

3. **WALK-IN:** Bring a copy of all the pages of this notice to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, 1st floor, Brooklyn, New York.

4. **TO WRITE FOR A FAIR HEARING:** Fill in the space below and send a copy of all pages of this notice to:

   Fair Hearing Section
   New York State Office of Temporary and Disability Assistance
   P.O. Box 22023,
   Albany, New York, 12201-2023

   Please keep a copy for yourself.

5. **OR ONLINE ON THE INTERNET.** Complete the online request form at the following Web page:

   https://www.otda.state.ny.gov/oah/FHReq.asp

☐ I want a fair hearing. The Agency's action is wrong because: _____

_____

Print Name of Client: _____ Name of Plan: _____
Signature of Client: _____ Date: _____
Address: _____ Phone #: _____
Case #: _____ CIN #: _____

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

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 a legal counsel, a relative, a friend or other person, or represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written or 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, pay stubs, receipts, medical 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 care through your managed care provider until the fair hearing decision is issued. However, if you lose the fair hearing, New York State may recover the cost of any Medical Assistance benefits that you should not have received.

If you do NOT want your aid to continue while waiting for the decision of the fair hearing, check the box below and send this page to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 22023, Albany, New York, 12201.

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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 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 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, contact New York Medicaid Choice at 1-888-401-6582, TTY: 1-888-329-1541, or write to us. You can send your request by fax: 917-228-8899, or mail it to: Record Access Unit, New York Medicaid Choice, P.O. Box 5016, New York, NY 10274.

If you want copies of documents from your case file, you should ask for them ahead of time. Usually, they will be sent to you within three working days of when you ask for them. If your hearing is within three working days of when you ask for them, your case file documents may be given to you at the fair hearing.

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 New York Medicaid Choice at 1-888-401-6582, TTY: 1-888-329-1541, or write to us. You can send your request by fax: 917-228-8899, or by mail it to: Record Access Unit, New York Medicaid Choice, P.O. Box 5016, New York, NY 10274.

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