New York

**Medicaid Choice**

**1-888-401-6582**

Ask ▪ Choose ▪ Enroll

New York State’s Medicaid managed care enrollment program

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

New Reason Code Indicator= C

[Date]

<Barcode> <Letter Code>

<Name>

<Address>

<City>, <State>, <Zip>

**Notice of Managed Long Term Care Medicaid Plan Disenrollment**

Dear [Consumer Name]: [CIN]

New York State changed **how nursing home benefits will be covered for people in Managed Long Term Care (MLTC) Medicaid Plans, also known as Partial Capitation Plans.** MLTC Medicaid plans will only cover 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]** (the “effective date” of your disenrollment).

This does not change your eligibility for Medicaid. You still qualify for Medicaid coverage of nursing home care because your local social services district has determined that you are financially eligible for such care and services. After **[Plan Disenrollment Effective Date**], your nursing home care will be paid by regular fee-for-service 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.

**Who determined 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.

**Can I return home or to another community setting?**

Yes. Being in a long-term nursing home stay does not prevent you from returning to the community if it is safe for you to do so.

If you want to return to the community, you can ask for an assessment to determine whether your needs can be met safely in the community. You can schedule an assessment with your plan by calling New York Medicaid Choice at 1-888-401-6582 (TTY: 1-888-329-1541). New York Medicaid Choice will work with you and your plan to arrange an assessment.

If you ask for an assessment before the effective date of your disenrollment, which is **[Plan Disenrollment Effective Date**], you will remain enrolled in your plan until your assessment is complete and you are notified of your MLTC Medicaid plan’s decision.

**What do I do if I have a pending request or appeal to reinstate or increase my home care?**

If you call New York Medicaid Choice at 1-888-401-6582 (TTY: 1-888-329-1541) and tell them you are waiting for a decision from your plan or a fair hearing decision about home care services, and we confirm this with your plan, you will remain enrolled in your plan until you receive a decision and any appeal is completed.

You can also request a fair hearing to appeal this notice. If you request a fair hearing with aid to continue before **[Plan Disenrollment Effective Date**] you will remain enrolled in your plan until the hearing is decided.

**What happens if I do not request a new assessment before I am disenrolled?**

If you do not ask for an assessment or a fair hearing with aid to continue before **[Plan Disenrollment Effective Date**], you will be disenrolled from <Plan Name>. You will continue to receive your nursing home care through regular Medicaid. Being disenrolled from your plan does not prevent you from returning to the community in the future if it is safe for you to do so.

**If you are able to safely leave the nursing home and return to the community within six months of** the date of your disenrollment you will be presumed eligible for enrollment into an MLTC Medicaid Plan. To re-enroll in an MLTC Medicaid Plan, contact NY Medicaid Choice.

To request an assessment after disenrollment, talk to the social worker at your nursing home or contact the Open Doors program about returning to the community. The Open Doors program provides support for people to return to their homes after a nursing home stay. To find out more about the Open Doors program, call 844-545-7108.

**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.Ourcounselors can help in all languages.

**You can also call ICAN, 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 appeal 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.

Thank you,

New York Medicaid Choice.

**(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.**

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

**http://otda.ny.gov/hearings/request/**

* 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.

* I do NOT want my aid to continue while waiting for the decision of the fair hearing. I understand if I lose the fair hearing I may be responsible for the cost of any Medical Assistance benefits that the fair hearing determines I should not have received.

**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.

**FH#299A-NYS-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. **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.**

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

**http://otda.ny.gov/hearings/request/**

* 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.

* I do NOT want my aid to continue while waiting for the decision of the fair hearing. I understand if I lose the fair hearing I may be responsible for the cost of any Medical Assistance benefits that the fair hearing determines I should not have received.

**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.

|  |  |
| --- | --- |
| **English** | This is an important document. If you need help to understand it, please call 1-855-789-4277. We can give you an interpreter for free. |
|  |  |
| **Español**Spanish | Éste es un documento importante. Si necesita ayuda para entenderlo, por favor llame al 1-855-789-4277. Le proporcionaremos un intérprete gratuito. |
|  |  |
| **繁體字**Traditional Chinese | **這是一份重要文件, 如果您需要翻譯服務閱讀此文件, 請撥打電話至** 1-855-789-4277**, 該項服務免費。** |
|  |  |
| **Kreyòl Ayisyen**Haitian Creole | Sa a se yon dokiman enpòtan. Si ou bezwen èd pou konprann li, tanpri rele: 1-855-789-4277. Y ap ba ou yon entèprèt gratis. |
|  |  |
| **Italiano**Italian | Il presente documento è importante. Per qualsiasi chiarimento può chiamare il numero 1-855-789-4277. Un interprete sarà disponibile gratuitamente. |
|  |  |
| **한국어**Korean | 이것은 중요한 문서입니다. 문서를 이해하는 데 있어 도움이 필요하시면, 연락해 주십시오: 1-855-789-4277. 무료통역이 제공됩니다. |
|  |  |
| **Русский**Russian | Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-789-4277. Переводчик предоставляется бесплатно. |

MLTC – Multi‐language Insert – 1019