Print Form

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

HOME AND COMMUNITY-BASED SERVICES MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

NOTICE OF INTENT TO DISCONTINUE FROM THE WAIVER PROGRAM

Name & Address of Waiver Participant:	Client Identification Number (CIN): _____ Notice Date: _____ Effective Date: _____

This is to inform you that your participation in the Home and Community-Based Services Medicaid Waiver for Individuals with Traumatic Brain Injury (TBI) is being **DISCONTINUED** as of the Effective Date above.

Your participation in the waiver is being **DISCONTINUED** for the following reason(s):

☐ You are determined to no longer be eligible for nursing home level of care, per Patient Review Instrument and SCREEN.

☐ Waiver services cannot safely maintain you in the community.

☐ You do not have a current service plan.

☐ Other _____

Explanation: _____

_____

_____

_____

The law that allows us to do this is Section 1915(c) of the Social Security Act.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE REST OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

_____
Regional Resource Development Specialist (RRDS)

_____
Print Name

_____
Address

_____
Telephone

_____
Address

cc: Guardian
Authorized Representative
Service Coordinator
NYS DOH TBI Waiver Program
Social Services District with fiscal responsibility
Social Services District in county of residence (If different from county of fiscal responsibility)

RIGHT TO 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 the Regional Resource Development Specialist (RRDS) discovers that the wrong decision has been made, or if, because of information you provide, the RRDS decides to change the decision, corrective action will be taken. You will receive a new Notice of Decision. You may ask for a conference by calling the RRDS at the telephone number listed on the first page of this notice or by sending a written request to the address listed on the first page of this notice. ***This is not the way to request a fair hearing.*** If you ask for a conference, you are still entitled to a fair hearing. Read below for fair hearing information.

If you only ask for a Conference, we will not keep your benefits the same while you appeal. Your benefits will stay the same only if you ask for a fair hearing. (See Continuing Your Benefits).

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 statewide toll free number at 1-800-342-3334. (PLEASE HAVE THIS NOTICE WITH WITH YOU WHEN YOU CALL) **OR**

2. **Fax:** Complete and fax a copy of this notice to (518) 473-6735 **OR**

3. **On-Line:** Complete and send the online request form at: https://www.otda.state.ny.us/oah/forms.asp**OR**

   If you cannot reach the New York State Office of Temporary and Disability Assistance by phone, by fax, or on-line, please write to ask for a fair hearing before 60 days from the date of this notice.

4. **Mail:** Complete and send a copy of this notice to the Fair Hearing Section, New York State Office of Temporary 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 & Disability Assistance, 14 Boerum Place, Brooklyn, New York **or** 330 West 34th Street, 3rd. Floor, NY, NY. Bring a copy of this notice with you.

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 the 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, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

☐ I want a fair hearing. The decision is wrong because: _____

_____

CONTINUING YOUR BENEFITS: If you request a fair hearing before the Effective Date stated on the front page of this Notice, you will continue to receive your benefits unchanged 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 1930, 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 Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking the yellow pages of your telephone book under "lawyers."

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your file. If you call or write to the RRDS, they 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 the RRDS, they will provide you with free copies of other documents from your file, which you think you may need for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the RRDS at the telephone number and address listed on the front page of this Notice. If you want copies of documents from your file, you should ask for them within a reasonable time before the date of the fair hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your file, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, please call or write the RRDS at the telephone number and address listed on the front page of this Notice.

Print Name _____ Client Identification Number (CIN) _____

Address _____ Telephone _____

Signature _____ Date _____