NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Notice of Determination for Disenrollment in the New York State Health Home Program

Notice Date _____ CIN Number _____

Effective Date (10 day Notice Required) _____

Health Home

Name The Mary Imogene Bassett Hospital dba Bassett Community Health Navigation

Address 1 Atwell Rd Cooperstown NY 13326

General Telephone Number for Questions or Help 1-607-547-4887 or 1-877-547-1753 (toll free)

Member

Name _____

Parent, Legal Guardian, Legally Authorized Representative, if any _____

Address _____

This is to advise you that effective _____ (Date) this agency Bassett Community Health Navigation (Name of Health Home) will

Disenroll you from the Health Home Program

You do not meet the criteria necessary for continued enrollment and you are being disenrolled from the Health Home Program, as of the effective date listed above, for the following reason(s):

☐ You no longer require Health Home Care Management Services because you do not meet the appropriateness criteria below (check all that apply)
- ☐ You have currently met all of your wellness and recovery goals
- ☐ You are no longer at risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- ☐ You currently have adequate social/family/housing support
- ☐ You currently have no serious changes in family relationships
- ☐ You currently have adequate connectivity with the healthcare system
- ☐ You currently adhere to treatments
- ☐ You currently do not have difficulty managing medications
- ☐ You no longer have impairments in activities of daily living, learning or cognition issues
- ☐ Other _____

☐ You are concurrently eligible or enrolled, along with either your child or caregiver in another Health Home

☐ You currently reside in an excluded setting (e.g., Residential Treatment Facility, Nursing Home, Incarceration etc.)

☐ You have been lost to follow up and we are unable to provide Health Home Care Management Services to you

☐ You no longer meet the Health Home chronic condition eligibility criteria. You must have either:
- Two or more chronic conditions OR
- One single qualifying chronic condition:
  - HIV/AIDS (Adults and Children) or
  - Serious Mental Illness (SMI) (Adults only) or
  - Serious Emotional Disturbances (SED) (Children only) or
  - Complex Trauma (Children only)

☐ You no longer have the appropriate type of Medicaid Coverage for Health Home Services.

This action is taken under NYS SSL 365-l

Health Home Representative

Signature: X _____

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

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 inform you in writing. You may ask for a conference by calling the number listed on the first page of this Notice of Determination or by sending a written request to us at the address listed at the top of the first page of this Notice of Determination. 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. You must request a fair hearing in the way described below. Also, if you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision please be sure to read and complete the section below entitled, '**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 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**
   On-Line: Complete and send the online request form at: http://www.otda.ny.gov/oah/forms.asp; **OR**
3) **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.**
4) **Walk In** (New York City only):
   Office of Temporary and Disability Assistance
   Office of Administrative Hearing
   14 Boerum Place – 1st Floor
   Brooklyn, New York 11201
5) **Speech and Hearing Impaired:**
   Contact the New York Relay Service at 711 or 1-800-622-1220.
   Request that the operator call 877-502-6155. Service at this number will only be provided to callers using TDD equipment.

☐ **I want a Fair Hearing.** This action is wrong because: _____

_____

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, health care bills, heating bills, medical verification, doctor's 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 until the fair hearing decision is issued. 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, the Health Home will send you a copy of the evidence packet within 10 business days of receiving notice from ODTA of the Fair Hearing date. The evidence packet contains information the Health Home used to make their decision about your Health Home enrollment, which will be provided to the hearing officer to explain their decision. If you do not get your evidence packet by the week before your hearing, call us at the telephone number listed at the top of page 1 of this Notice of Determination and ask for it. If there is not enough time to mail the evidence packet to you, the Health Home will bring a copy of it to you at the hearing.

You have the right to look at your case file. If you call us ahead of time at the telephone number listed at the top of page 1 of this Notice of Determination or write to us within a reasonable time before the date of the hearing, we will provide you free copies of other documents from your file which you think you may need to prepare for your 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 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.

Print Name: _____ Client Identification Number (CIN): _____

Address: _____ Telephone Number: _____

Signature: X _____ Date: _____

Original – Medicaid Member/Parent/Guardian/Legally Authorized Representative

Copy as Applicable – Quality Management Specialist (QMS) Local Department of Social Services or Division of Juvenile Justice and Opportunities for Youth, Health Care Integration Agency, Case Planning Agency, Caregiver, Voluntary Foster Care Agency, Medical Consenter

This document is available in other languages. This notice can be read to you in another language.