

Notice of Decision Authorization

Name of Waiver Participant

Address

Client Identification Number (CIN)

Notice Date

This is to inform you that your participation in the 1915(c) Home and Community-Based Services Medicaid Waiver for Nursing Home Transition and Diversion (NHTD) or Traumatic Brain Injury (TBI) has been:

NHTD

TBI

AUTHORIZED effective from _____. The services you are authorized to receive are identified in your Service Plan. Your Service Plan will be reviewed every six (6) months and revised annually (every twelve (12) months) or more frequently as appropriate.

The laws that allow us to do this are: Section 1915(c) of the Social Security Act and Section 366 (6-a) of the Social Services Law, or Sections 2740, 2741 and 2742 of the Public Health Law

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 (Print)

Regional Resource Development Specialist (Signature)

Name of Regional Resource Development Center (RRDC)

Address

Telephone

cc: Legal Guardian
Authorized Representative Service Coordinator
NYS DOH NHTD and TBI Waiver Program

RIGHT TO CONFERENCE: You may have a conference with the Regional Resource Development Specialist (RRDS) to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the 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.

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

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

Effective date that your waiver was denied _____

Your Name (Print) _____

Your Signature _____

Address _____

Telephone _____

Client Identification Number (CIN) _____

Date _____

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.