NOTICE OF DECISION TO DENY
(FISCAL ASSESSMENT)
PERSONAL CARE SERVICES

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADI
CASE NUMBER	CIN NUMBER	
CASE NAME AND ADDRESS		
		GENERAL TELEPHONI OR Agency Confe Fair Hearin and assistar Record Acces Legal Assis
Office No.	Unit No. / Worker No.	Unit or Worker Na

This is to inform you that we intend to deny your request _____.

We are taking this action because:

- The average monthly cost of your personal care services exc monthly cost of residential health care facility (RHCF) ser financially responsible for your Medical Assistance.

  Based on your fiscal assessment, the average monthly $_____ and 90% of the average cost of RHCF services cost of your services is $_____ OVER the 90% of RHCF

- Your case does not meet any of the EXCEPTION CRITERIA liste

THE REGULATION WHICH ALLOWS US TO DO THIS IS 18 NYCRR 505.14.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, IN LIVING ARRANGEMENTS OR ADDRESS.

Personal Care Services (Fiscal Assessment)- DENIAL

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If y
one as soon as possible. At the conference, if we discover that we mad
information you provide, we determine to change our decision , we w
notice. You may ask for a conference by calling us at the number on the
written request to us at the address listed at the top of the first page
asking for a conference. It is not the way you request a fair hearing. If you ask for a co
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

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara,

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario,
County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jef
Oswego, St. Lawrence, Tompkins or Tioga County: (

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, E
Montgomery, Nassau, Orange, Otsego, Putnam, Re
Schoharie, Suffolk , Sullivan, Ulster, Warren, Wa
8781

OR

(2) Writing: By sending a copy of this notice completed, to the Fair H
Social Services, P.O. Box 1930, Albany, New York 12201. Please keep

---+
+--- I want a fair hearing. The Agency's action is wrong because:

_____

_____

_____

Signature of Client _____ Date _____

Address....._____

Phone Number....._____Case Number _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HE

If you request a fair hearing, the State will send you a notice informin
You have the right to be represented by legal counsel, a relative
yourself. At the hearing you , your attorney or other representative wil
oral evidence to demonstrate why the action should not be taken, as well
appear at the hearing. Also, you have a right to bring witnesses to sp
hearing any documents such as this notice, medical bills, medical verific

EXCEPTION CRITERIA
FOR DENIAL OF PERSONAL CARE SERVICES

The social services official has determined that you do not meet a
disagree with this determination and you think that you meet at least one
ask for a State fair hearing. Please refer to the attached notice to le
hearing.

The exception criteria are as follows:

1. You are not medically eligible for residential health care f
long-term care services, including other residential long-term care servi
services.

2. Personal care services are cost-effective when compared
appropriate for your needs. The social services official determines whet
by following these rules:

a. If you would be placed in a general hospital, the social s
costs of the personal care services you are reasonably expected to need f
care in a general hospital. The Department of Health determines t
hospital by adding the payments made to all general hospitals in the regi
which you would be classified, dividing the result by the sum of the grou
in such DRG, multiplying the result by 365 and further dividing by 12.

b. If you would be placed in an intermediate care facility for
services official compares the average monthly costs of the personal care
for 12 months to the regional rate of payment for care in an intermedia
disabled, as determined by the Department in consultation with the O
Disabilities.

c. If you would be placed in a residential health care facility
compares the average monthly costs of the personal care services you are
the average monthly costs of residential health care facility services in
who are classified in the same resource utilization group (RUG) cat
classified.

d. If you would be placed in other residential long-term care ser
services, the social services official compares the average monthly cos
reasonably expected to need for 12 months to the average monthly costs, a
residential long-term care services or non-residential long-term care ser

3. You are employed. You are employed if you work and your
activities for which you are paid or from which you receive or could rece
determines whether you are employed by using the federal regulations t
seeks disability benefits under Title II of the federal Social Security
activity." These regulations are located at 20 C.F.R. 404.1571 through 4

A. You are in school. The educational program in which you are en
on preschool special education established in accordance with Section 441
special education established in accordance with Section 4402 of the Educa

B. You are the parent or legal guardian of a child who lives with yo
   a. the child is younger than 18; or
   b. the child is younger than 21 and is enrolled in an educa
      Regents; or
   c. the child is 18 years old or older and is blind or di
      Department's regulations (18 NYCRR Part 360, Subpart 360-5)

NOTICE OF DECISION TO DISCONTINUE
PERSONAL CARE SERVICES
(Fiscal Assessment)

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADI
CASE NUMBER	CIN NUMBER	
CASE NAME AND ADDRESS		
		GENERAL TELEPHONI OR Agency Conf Fair Hearin and assista Record Acce Legal Assis
Office No.	Unit No. / Worker No.	Unit or Worker Na

This is to inform you that we intend to discontinue your personal car services that you are currently receiving will continue until the app become available. This discontinuance will not happen before the _____.

We are taking this action because:

- The average monthly cost of your personal care services exc monthly cost of residential health care facility (RHCF) ser financially responsible for your Medical Assistance.

  Based on your fiscal assessment, the average monthly $_____ and 90% of the average monthly cos $_____. The cost of your services is $_____

- Your case does not meet any of the EXCEPTION CRITERIA liste

Based on your current medical condition, you must be referre services:

_____

_____

Personal Care Services (Fiscal Assessment) - Discontinue

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If y
one as soon as possible. At the conference, if we discover that
information you provide, we determine to change our decision , we will
notice. You may ask for a conference by calling us at the number on
written request to us at the address listed at the top of the first page
asking for a conference. It is not the way you request a fair hearing. If you ask for a
entitled to a fair hearing. If you want to have your benefits continue
fair hearing decision, you must request a fair hearing in the way descri
will not result in continuation of benefits. Read below for fair hearing

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara,

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario,
County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jef
Oswego, St. Lawrence, Tompkins or Tioga County: (

If you live in: Albany, Clinton, Columbia, Delaware, Dutche
Hamilton, Montgomery, Nassau, Orange, Otsego
Schenectady, Schoharie, Suffolk , Sullivan, Ulste
(518) 474-8781

OR

(2) Writing: By sending a copy of this notice completed, to the Fair H
Social Services, P.O. Box 1930, Albany, New York 12201. Please keep

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+--+ I want a fair hearing. The Agency's action is wrong because:

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_____

_____

Signature of Client _____ Date _____

Address....._____

Telephone Number...._____ Case Number _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HE

If you request a fair hearing, the State will send you a notice inform
You have the right to be represented by legal counsel, a relative, a f
yourself. At the hearing you , your attorney or other representative wil
oral evidence to demonstrate why the action should not be taken, as well

EXCEPTION CRITERIA

FOR DISCONTINUANCE OF PERSONAL CARE SERVICES

The social services official has determined that you do not n
This means that you must be referred to long-term care services that are a
personal care services will continue until the other appropriate long-ter

If you disagree with this determination and you think that you
criteria, you may ask for a State fair hearing and for your personal car
fair hearing decision is issued (aid continuing). Please refer to the a
State fair hearing and aid continuing.

The exception criteria are as follows:

1. You are not medically eligible for residential health care facil
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services.

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in such DRG, multiplying the result by 365 and further dividing by 12.

b. If you would be placed in an intermediate care facility
services official compares the average monthly costs of the personal care
for 12 months to the regional rate of payment for care in an inter
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Disabilities.

c. If you would be placed in a residential health care facility
compares the average monthly costs of the personal care services you are
the average monthly costs of residential health care facility services i
who are classified in the same resource utilization group (RUG) category a
classified.

d. If you would be placed in other residential long-term car
care services, the social services official compares the average monthly
are reasonably expected to need for 12 months to the average monthly cost
other residential long-term care services or non-residential long-term ca

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activities for which you are paid or from which you receive or could rec
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