ATTACHMENT VI(a)

NOTICE OF CREDIT DUE TO UNCOVERED EXPENSES
(PAY-IN PROGRAM)

NOTICE DATE:	NAME AND ADDRESS OF AGENCY/
CASE NUMBER / CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS	
	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
	OR Agency Conference Fair Hearing information and assistance Record Access Legal Assistance informat

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TEL

We have decided to credit your Pay-In account based on the following bill(s) you submitted for medical services not covered by the Medical Assistance program:

	Date of Service	Description of Service	Amount
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

The amount that you paid in to this agency for this period is $_____. The amount of your uncovered medical services is $_____. Because you have already paid us your excess income for this period, we are giving you a credit of $_____. This reduces the amount you must pay to get coverage in the future as follows:

For the month(s) of _____, you are eligible for outpatient coverage and you do not need to make any payment to this agency.

For the month of _____, you must pay $_____, in order to receive coverage.

Beginning _____, you must again pay the full excess income amount of $_____, in any month in which you want Medical Assistance coverage.

The LAW(S) AND/OR REGULATION(S) which allow us to do this is Section 366.2(b) of the Social Services Law and 18 NYCRR 360-4.8.

Pay-In Program: Credit Due to Uncovered Expenses

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a ask for one as soon as possible. At the conference, if we discover that we made a wrong of information you provide, we determine to change our decision, we will take correct new notice. You may ask for a conference by calling us at the number on the first page sending a written request to us at the address listed at the top of the first page of t is used only for asking for a conference. It is not the way you request a fair hearing. If you conference you are still entitled to a fair hearing. Read below for fair hearing inform

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

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

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

If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (7 4868

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or County: (716) 266-4868

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneid Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 422-4868

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilt Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schene Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474

If you live in: Nassaua or Suffolk County: (516) 739-4868

OR

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

[ ] I want a fair hearing. The Agency's action is wrong because:

_____

_____

Name:_____ Case Number

Address_____

Signature of Client _____Da

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 hearing. You have the right to be represented by legal counsel, a relative, a frien represent yourself. At the hearing you, your attorney or other representative will h present written and oral evidence to demonstrate why the action should not be taken, as question any persons who appear at the hearing. Also, you have a right to bring witne favor. You should bring to the hearing any documents such as this notice, paystubs, heating bills, medical verification, letters, etc. that may be helpful in presenting you

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such as

ATTACHMENT VI(b)

NOTICE OF REFUND DUE TO UNCOVERED EXPENSES
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CASE NUMBER	CIN/RID NUMBER	
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		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
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OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TEL

We are giving you a refund from your Pay-In account based on the following bill(s) you submitted for medical services not covered by the Medical Assistance program:

	Date of Service	Description of Service	Amount
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

The amount that you paid in to this agency for this period is $_____. The amount of your uncovered medical services is $_____. Because you have already paid us your excess income for this period, we are sending you a check for $_____. This amount is either the amount of the incurred bill(s), or the amount that you paid us, whichever is less.

The LAW(S) AND/OR REGULATION(S) which allow us to do this is Section 366.2(b) of the Social Services Law and 18 NYCRR 360-4.8.

Regulations require that you immediately notify this Department of any

Pay-In Program: Refund Due to Uncovered Expenses

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Name:_____ Case Number

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Signature of Client _____Da

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LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such

ATTACHMENT VI(c)

NOTICE OF CREDIT DUE TO REVIEW OF MEDICAL ASSISTANCE CLAIMS
(PAY-IN PROGRAM)

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/
CASE NUMBER	CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS		
		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP
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OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TEL

We have completed a review of the Medical Assistance claims paid on your behalf for the period _____ to _____. During this period, you elected to pay your excess income to this agency for the months you wanted to receive Medical Assistance coverage.

Based on this review, we have found that the amount that you paid to us was more than the amount that was billed to the Medical Assistance Program. The following explains how we determined the amount you overpaid us.

+-+
+-+ ONE MONTH EXCESS

You made a separate payment for each month you wanted coverage in the period and received outpatient coverage for those months. We looked at the amount paid for claims in each month and compared the total to the payment you made for that month. We determined you overpaid $_____ during this period.

+-+
+-+ SIX-MONTH EXCESS

You made one payment to cover a six-month period and received full coverage. We looked at the total of all claims paid in the six-month period, and compared the total to the payment you made for six months. We determined you overpaid $_____ during this period.

Because of this overpayment, we are giving you a credit of $_____. This reduces the amount you must pay to get coverage in the future as follows:

For the month(s) of _____, you

Pay-In Program: Credit Due to Review of Medical Assistance Claims

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a ask for one as soon as possible. At the conference, if we discover that we made a wrong of information you provide, we determine to change our decision, we will take correcti new notice. You may ask for a conference by calling us at the number on the first sending a written request to us at the address listed at the top of the first page of th is used only for asking for a conference. It is not the way you request a fair hearing. If yo conference you are still entitled to a fair hearing. Read below for fair hearing inform

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Name:_____ Case Number

Address_____

Signature of Client _____Da

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You made one payment to cover a six-month period and received full coverage. We looked at the total of all claims paid in the six-month period, and compared the total to the payment you made for six months. We determined you overpaid $_____ during this period.

Because of this overpayment, we are sending you a check for $_____, the amount of your overpayment.

The LAW(S) AND/OR REGULATION(S) which allow us to do this is Section

Pay-In Program: Refund Due to Review of Medical Assistance Claims

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