NOTICE OF DECISION TO REDUCE
(FISCAL ASSESSMENT)
HOME HEALTH SERVICES

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

We are reducing your Home Health Services effective _____.

You will receive services FROM _____ TO _____ as long as Assistance and your service needs do not change.

Your services are being reduced:

FROM: (LIST SERVICES HERE, NURSING, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, HOME HEALTH AIDE SERVICES, etc. DETAIL FREQUENCY OF EACH SERVICE.)

_____

_____

_____

TO: (LIST SERVICES HERE, NURSING, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, A HOME HEALTH AIDE SERVICES, etc. DETAIL, FREQUENCY OF EACH SERVICE)

_____

_____

_____

BECAUSE:

RIGHT TO A CONFERENCE: You may have a conference to review these actions. I
for one as soon as possible. At the conference, if we discover that we
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. If you want to have your benefits contin
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, S

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

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

If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jef
Oswego, St. Lawrence, Tompkins or Tioga County: (315

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

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 ....._____

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
appear at the hearing. Also, you have a right to bring witnesses to s
hearing any documents such as this notice, medical bills, medical verific
presenting your case.

NOTICE OF DECISION TO DISCONTINUE
(FISCAL ASSESSMENT)
HOME HEALTH SERVICES

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

This is to inform you that we intend to discontinue Medical Assistanc
payment for the home health services that you are currently receiving
term services listed below become available. This discontinuance
this notice which is _____.

We are taking this action because the Local Professional Director or

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

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

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

- Based on your current medical condition, you must be refer
  care services:

_____

_____

_____

Home Health Services - (Fiscal Assessment)-Discontinue

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County: (716) 266-4868

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

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8781

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Signature of Client _____ Date _____

Address ....._____

Telephone Number ..._____ Case Number _____

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EXCEPTION CRITERIA
FOR DISCONTINUANCE OF HOME HEALTH SERVICES

The local professional director, or his or her designee, has d following exception criteria. This means that you must be referred to for your needs. However, the Medical Assistance (MA) program will contin the other appropriate long-term care services become available to yo providing you with home health services will notify you when other a available to you.

If you disagree with the determination of the local professional di that you meet at least one of the following exception criteria, you may a health services to continue unchanged until the fair hearing decision is attached notice to learn how you may ask for a State fair hearing and aid

The exception criteria are as follows:

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

2. Home health services are cost-effective when compared to appropriate for your needs. The local professional director or his or h services are cost-effective by following these rules:

a. If you would be placed in a general hospital, the local p average monthly costs of the home health services you are reasonably expe monthly costs of care in a general hospital. The Department of Health de a general hospital by adding the payments made to all general hospitals i (DRG) in which you would be classified, dividing the result by the sum classified in such DRG, multiplying the result by 365 and further dividin

b. If you would be placed in an intermediate care facility professional director or designee compares the average monthly costs of t expected to need for 12 months to the regional rate of payment for developmentally disabled, as determined by the Department in consultatio Developmental Disabilities.

c. If you would be placed in a residential health care facilit director or designee compares the average monthly costs of the home healt need for 12 months to the average monthly costs of residential health district for recipients who are classified in the same resource utilizati which you would be classified.

d. If you would be placed in other residential long-term care care services, the local professional director or designee compares services that you are reasonably expected to need for 12 months to the av Department, of such other residential long-term care services or non-resi

3. You are employed. You are employed if you work and your work activities for which you are paid or from which you receive or cou director or designee determines whether you are employed by using the fed whether someone who seeks disability benefits under Title II of "substantial gainful activity." These regulations are located at 20 C.F.