STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 00 OMM/ADM-6

TO: **Commissioners of Social Services**

DIVISION: Office of Medicaid Management

DATE: July 17, 2000

SUBJECT: Post-eligibility Treatment of Income of Institutionalized Individuals: Application of Income to Cost of Care

SUGGESTED DISTRIBUTION:	Medical Assistance Staff Fair Hearing Staff Legal Staff QA&A Staff Staff Development Coordinators
CONTACT PERSON:	Your Local District Liaison at 518-474-9130 for Upstate and 212-268-6855 for New York City
ATTACHMENTS:	See Appendix I for listing of Attachments

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
91 ADM-17 89 ADM-47		358-2.23 358-3.3 360-1.4 (c) & (k) 360-4.9 360-4.10	SSL 366 SSA Sect. 1924 42 CFR 435.725 & .832		

I. PURPOSE

This Administrative Directive (ADM) advises social services districts of the actions to be taken when a change in an institutionalized Medicaid recipient's income or other circumstances results in an increased or decreased amount of net available monthly income (NAMI). The NAMI amount is the portion of the recipient's monthly income which must be applied toward the cost of care.

II. BACKGROUND

For individuals in permanent absence status in a medical facility, or for an institutionalized spouse as defined in Section 360-4.10(a)(7) of State regulations, after Medicaid eligibility is established, post-eligibility rules are used to determine the amount of income that is to be applied toward the cost of care. When an increase in an individual's income or other circumstances results in an increase in the NAMI amount, timely and adequate notice must be provided to the individual. Timely notice must be mailed at least 10 days in advance of the date the social services district increases the NAMI amount. In addition, because income contributions are applied on a monthly basis, any increase in an individual's NAMI is made effective on the first day of the month which is at least 10 days after the notice is mailed.

Until timely notice is provided, no action may be taken to increase the NAMI amount that an individual is required to pay toward the cost of his or her care. In instances where a change in a recipient's income or circumstances goes unreported, the amount of Medicaid overpayment can be significant.

Overpayments resulting from a change in a recipient's income or circumstances may be recouped by:

- asking the recipient to voluntarily repay the agency for the amount of the overpayment;

- commencing appropriate court actions to recover incorrectly paid Medicaid;

- utilizing an option under federal post-eligibility rules to project and reconcile income at the end of a specific budget period or when a significant change occurs.

Under this last option, an adjustment is made to an individual's NAMI in a future month(s) to reflect the amount that would have been contributed had the change in income or circumstances been taken into account when the change occurred. To reduce Medicaid overpayments which can occur in the post-eligibility process, social services districts are instructed to use this method of reconciling income contributions.

III. PROGRAM IMPLICATIONS

In accordance with the post-eligibility rules under federal regulations 42 CFR 435.725 and 435.832 (and the spousal impoverishment provisions at 42 U.S.C. 1396r-5), in determining the amount of an individual's income to be applied toward the cost of care, monthly income will be projected for a prospective budget period. At the end of the budget period, or when any significant change occurs, the social services district must reconcile projected income with actual income received.

If a change in income or circumstances results in an increase in the amount that an individual should have paid to a facility, an adjustment will be made to the individual's NAMI in a future month(s) (following 10-day notice) to reflect the amount that should have been contributed for the budget period. In situations where the full amount of an adjustment together with an individual's on-going NAMI exceeds the monthly Medicaid rate, the adjustment is limited to the difference between the on-going NAMI and the Medicaid rate. The balance of the adjustment is carried over and added to the following month's NAMI. This process continues until the full amount of an adjustment has been applied toward the cost of care.

It should be noted that adjustments may only be made in cases where an individual continues to be financially eligible for Medicaid. If an income change or change in circumstances renders an individual ineligible for Medicaid, the social services district is not able to make an adjustment prospectively. However, in such situations, the social services district may seek to recoup the amount of Medicaid overpayments by asking the individual to voluntarily repay the district or by pursuing recovery through appropriate court actions.

The following are the most common situations resulting in a NAMI increase:

- there is an increase in an institutionalized individual's income (including receipt of a lump sum payment or other payment that is considered income in the month of receipt) and 10-day notice cannot be provided in advance of the month the income is received;

- a community spouse's income increases, which reduces the deduction for the community spouse monthly income allowance;

- spousal impoverishment rules cease to apply due to the institutionalization of the community spouse.

In instances where a reconciliation results in a decrease in the amount that an individual should have contributed toward the cost of care, the individual's NAMI amount will be decreased prospectively. This will serve to: reimburse the individual, if the individual actually paid the incorrect NAMI amount to the provider; or furnish the individual with the necessary income to pay the provider, if payment has not been made.

Note: This procedure will no longer require the provider to refund the recipient the amount he/she overpaid and re-submit an adjusted Medicaid claim.

The adjustments discussed in this ADM deal with NAMI changes due to income. For funds subject to evaluation as resources, regular budgeting procedures apply. Consequently, if an individual is found to have excess resources during a budget period, and has retained the resources, the individual is ineligible for Medicaid until resources are reduced to the Medicaid resource level or the individual incurs medical bills equal to the amount of the excess. If in the month following the 10-day notice, the individual will incur medical bills equal to or greater than the total amount of the excess resources and monthly income contribution, the excess resources can be added to the individual's income contribution for the cost of care. If the excess resources together with any income contribution exceed the amount of medical expenses that are expected to be incurred the month following 10-day notice, the individual's Medicaid case will be closed, unless the individual elects to voluntarily repay the district for the amount of past Medicaid paid on his/her behalf up to the amount of the excess resources.

To inform individuals who are budgeted with a NAMI amount that an adjustment will be made to the NAMI amount if estimated income differs from actual income received, language has been added to the "Notice of Intent to Establish a Liability Toward Chronic Care" (LDSS-4022 Rev. 5/99) and the "Notice of Intent to Change the Contribution Toward Chronic Care Costs" (LDSS-4021 Rev. 8/98). In addition, to advise individuals of the calculations used to determine the amount of such an adjustment and resulting NAMI change, a new notice has been developed ("Important Notice Concerning Your Contribution Toward Chronic Care Costs").

IV. REQUIRED ACTION

Social services districts are to take the following actions when changes in a recipient's income or circumstances result in a change in the individual's NAMI.

Note: These procedures apply to individuals who are in permanent absence status, and are to be used once chronic care budgeting begins (the first day of the month following the month in which an individual is determined to be in permanent absence status).

A. Determination of Income

In determining the amount of an individual's income to be applied toward the cost of care, social services districts are to project total monthly income for the prospective budget period. For income that is received regularly in fixed amounts (e.g., social security benefits), the projection is to be based on the current amount received. For income that is irregularly received or that fluctuates in amount (e.g., interest and dividends), social services districts should base the projection on the average amount received in the preceding six-month period. For income that is received annually (e.g., an annuity payment), the projection should be based on an average monthly amount.

Social services districts are to project monthly income solely on the basis of income currently being received and expected to continue during the prospective budget period. Income that an individual may receive in the future is not to be considered. For example, if an individual owns unoccupied rental property which he or she intends to rent within the next few months, no rental income can be budgeted until the rental income is actually available. In such case, the district may want to use an anticipated future action (AFA) code to flag the case for review the month that the rental income is expected to be available.

B. Income Adjustments

The following example is provided for use in subsequent sections of the ADM to illustrate how a reconciliation/adjustment is to be made.

Case Situation: Recipient is in a nursing facility. His/her only income is social security and a pension.

Events -

- In January, the recipient receives a COLA increase in social security and an unreported $50 increase in his/her pension.

- The social services district determines that the social security increase does not render the individual ineligible, but does increase the amount the recipient is to contribute toward the cost of care ($637 NAMI).

- In April, when the district finds out about the unreported increase in the individual's pension, the district determines whether the additional increase in income renders the individual ineligible or only results in a larger NAMI amount. The district determines that the increase results only in a larger NAMI amount ($637 NAMI increased to $687).

- Timely and adequate notice is mailed to the recipient on May 10th. The district takes action to make an adjustment to the individual's NAMI amount effective June 1st.

1. Reconciliation of Income

At recertification, or when notified of a change in a recipient's income or circumstances, the social services district must reconcile estimated income with actual income received. The reconciliation may be made for a period up to six months prior to the month the reconciliation is done. Since timely notice must be provided before the district can increase an individual's NAMI, the month(s) that it will take to provide timely notice must be taken into account in determining the amount that should have been contributed. For example, in the case example provided, the months to consider in reconciling the recipient's income would be

January, the month of the pension increase, through May, the month during which timely notice is provided. Since the individual's NAMI can be increased effective June 1st, the month of June is not part of the reconciliation period.

Although State regulations do not require timely notice to be provided when action is taken to reduce an individual's NAMI, social services districts are instructed to provide timely notice when a NAMI reduction involves an adjustment. The 10-day notification period will serve to inform the recipient, Power of Attorney or representative of the NAMI change prior to making the next month's payment. This time period is also needed in order to update the NAMI on the Principal Provider Subsystem.

When reconciling income it will be important for social services districts to determine the effective month of an income change. While most income increases are effective the month in which the increased income is received, if income changes because spousal impoverishment rules cease to apply, the change in available income is effective the first month following the month in which the change in the couple's circumstances occurred.

2. Computing the Amount of an Adjustment

The full amount of an adjustment from an increase/decrease in an individual's income is the difference between what was contributed toward the cost of care and the amount that should have been contributed. In the example provided, the increase in the individual's pension resulted in a $50 a month increase in the amount to be contributed toward the cost of care ($637 NAMI increased to $687). The total adjustment for the reconciliation period (January through May, five months) would be $250. The individual would be advised in the notice provided May 10th that he/she is required to contribute $937 toward the cost of care for June ($250 adjustment + $687 increased monthly contribution due to pension increase). Effective July 1, the monthly contribution would be reduced to $687.

Note: Had the example involved a $50 decrease in the individual's income ($637 - $50 = $587) for the same reconciliation period, the NAMI for June would be reduced to $337 ($587 reduced monthly contribution due to decrease in income - $250 adjustment). Effective July 1, the NAMI would be $587.

In determining the amount that an individual's NAMI is to be increased, the adjustment and the individual's on-going NAMI cannot exceed the monthly Medicaid rate for the type of services the individual is receiving (i.e., nursing home level of care, or in the case of an institutionalized spouse, long term home health care or acute care in a hospital). If the full amount of an adjustment and the on-going NAMI exceeds the applicable Medicaid rate, the excess amount is to be carried over and applied to the subsequent month's NAMI.

For example, if an individual has an on-going NAMI of $3,500 and a $1,500 adjustment, and the Medicaid rate is $4,500, the first month's adjustment would be limited to $1,000 ($4,500 - $3,500 = $1,000). The total NAMI would be $4,500. The remaining balance of the adjustment ($1,500 - $1,000 = $500) would be added to the NAMI for the following month. The total NAMI would be $4,000. For subsequent months, the NAMI would be changed to $3,500, the on-going NAMI amount.

Note: For purposes of the above calculation, any available third party insurance benefits must be considered in determining the amount of Medicaid expenditures for a particular month. After applying any third party insurance benefits, the total amount of an individual's on-going NAMI and adjustment amount is compared to the amount of Medicaid expenditures for the month. For example, if in the above scenario, insurance covered $500 of the services provided each month, the Medicaid rate of $4,500 would be reduced to $4,000. The $4,000 potential Medicaid payment would decrease the first month's adjustment to $500 instead of $1,000.

When reconciling income due to the receipt of a lump sum payment, the amount of the adjustment cannot exceed the difference between the individual's NAMI and the applicable Medicaid rate for the month of receipt. If the lump sum payment, or a portion thereof, is retained beyond the month of receipt, the amount retained is subject to resource rules.

To assist social services districts in computing the amount of an adjustment, a "NAMI Adjustment Worksheet" has been developed (Attachment I). Social services districts may find this worksheet helpful in determining an individual's adjustment. Copies of the worksheet may be reproduced locally. See Attachment II for an example of the worksheet as it would be completed for the example presented in this ADM.

C. Notices

1. Form LDSS-4022: Notice of Intent to Establish a Liability Toward Chronic Care, and LDSS-4021: Notice of Intent to Change the Contribution Toward Chronic Care Costs

To notify individuals who are budgeted with a NAMI that the NAMI amount is based on projected income and subject to an adjustment if a change in income or circumstances occurs, the following language has been added to the LDSS-4022 (Rev. 5/99) and the LDSS-4021 (Rev. 8/98):

> "NOTE: Your monthly income contribution is based on a projection of income expected to be received. Adjustments will be made if your income or circumstances change."

Copies of these notices can be found as Attachments III and IV to this directive.

2. New Notice: Important Notice Concerning Your Contribution Toward Chronic Care (Attachment V)

When a change in a chronic care recipient's income or circumstances results in an adjustment in the recipient's NAMI, social services districts must use the new mandated notice entitled "Important Notice Concerning Your Contribution Toward Chronic Care". The notice informs the individual of the amount of the adjustment and the method used to determine the amount. This notice is to be used in place of the LDSS-4021 in all chronic care change situations involving an adjustment. Similar to the LDSS-4021 and DSS-4022, a copy of the new notice must also be sent to the medical provider and community spouse, if applicable. See Attachment VI for an example of the new notice as it would be completed for the example presented in Section IV.B. of this ADM.

To ensure that usage of the new notice begins immediately, districts are instructed to reproduce the attached copy (Attachment V) until this notice is available.

V. ADDITIONAL INFORMATION

To notify medical providers of this change in procedures, information will be included in a future issue of the "Medicaid Update". It will be important for providers to use the exact contribution amount which has been approved by the social services district when submitting a claim to Medicaid.

VI. SYSTEMS IMPLICATIONS

A. MBL

The calculation of the NAMI amount that an individual should have contributed toward the cost of care may be done using regular budgeting procedures. This budget may not be the budget that will be stored on MBL. For example, if an income increase was for a limited time period (i.e. a lump sum payment that is only income in the month received), the budget that the district would store would not include the lump sum payment. The calculation of the full amount of an adjustment must be done off line.

B. Principal Provider Subsystem

Once the amount of an adjustment is determined, this amount together with the on-going monthly NAMI is the amount to be entered in the Principal Provider Subsystem. A second entry will be required for the subsequent month's NAMI.

VII. EFFECTIVE DATE

The provisions of this ADM are effective July 1, 2000.

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management

Listing of Attachments

Attachment I: NAMI Adjustment Worksheet (available on-line)

Attachment II: NAMI Adjustment Worksheet - Increase Example (available on-line)

Attachment III: LDSS-4022 "Notice of Intent to Establish a Liability Toward Chronic Care" (not available on-line)

Attachment IV: LDSS-4021, "Notice of Intent to Change the Contribution Toward Chronic Care" (not available on-line)

Attachment V: New Notice "Important Notice Concerning Your Contribution Toward Cost of Care" (not available on-line)

Attachment VI: New Notice Example (not available on-line)

Attachment I

NAMI ADJUSTMENT WORKSHEET

Client's Name: _____
CIN: _____

Today's Date: _____

Income Source/Reason for Change: _____

_____

Effective Date of Increase/Decrease _____
or
Effective Date of Income _____

A. New NAMI Amt. (From MABEL) $_____

B. Previous NAMI Amt. $_____

C. Monthly Difference $_____
(Subtract Lower Amt. From Higher Amt.)

D. No. of Months in Reconciliation
Period (From _____ To _____*) _____ month(s)

E. Total Adjustment to NAMI (C x D) $_____

F. Monthly MA Rate for Nursing Facility $_____

G. NAMI Increase - If Total Adjustment (E) Plus On-going NAMI (A) Greater Than Monthly MA Rate (F), Limit NAMI Increase To The MA Rate. ADD Excess Adjustment To NAMI For The Next Month.

NAMI Decrease - If Total Adjustment (E) is Greater Than On-going NAMI (A), Subtract Excess Adjustment From The Next Month's NAMI.

H. Increased/Decreased NAMI for _____ (A) $_____

I. Total NAMI for _____ (A +/- E) $_____
(Includes Adjustment)

Total NAMI for _____ (A +/- remaining adjust.) $_____

J. On-going NAMI Effective _____ $_____

* If 10-day notice can be provided by the 1st of the next month, enter current calendar month as end month for retroactive period. If after the 1st of the month, enter the next calendar month as end month for retroactive period.

_____
Worker Signature

Attachment II

NAMI ADJUSTMENT WORKSHEET

Client's Name: _____
CIN: _____

Today's Date: **April 23, 1999**

Income Source/Reason for Change: **Increase in Pension**

Effective Date of Increase/Decrease **January 1, 1999**
or
Effective Date of Income _____

A. New NAMI Amt. (From MABEL) $ **687**

B. Previous NAMI Amt. $ **637**

C. Monthly Difference $ **50**
(Subtract Lower Amt. From Higher Amt.)

D. No. of Months in Reconciliation Period (From **Jan** To **May** *) **5** month(s)

E. Total Adjustment to NAMI (C x D) $ **250**

F. Monthly MA Rate for Nursing Facility $ **5,536**

G. NAMI Increase - If Total Adjustment (E) Plus On-going NAMI (A) Greater Than Monthly MA Rate (F), Limit NAMI Increase To The MA Rate. ADD Excess Adjustment To NAMI For The Next Month.

NAMI Decrease - If Total Adjustment (E) Greater Than On-going NAMI (A), Subtract Excess Adjustment From The Next Month's NAMI.

H. Increased/Decreased NAMI for **June** (A) $ **687**

I. Total NAMI for **June** (A +/- E) $ **937**
(Includes Adjustment)

Total NAMI for _____ (A +/- remaining adjust.) $ **N/A**

J. On-going NAMI Effective **July** $ **687**

* If 10-day notice can be provided by the 1st of the next month, enter current calendar month as end month for retroactive period. If after the 1st of the month, enter the next calendar month as end month for retroactive period.

_____
Worker Signature

IMPORTANT NOTICE CONCERNING YOUR CONTRIBUTION TOWARD CHRONIC CARE

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
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 information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We were recently informed of a change in your income and/or circumstances which requires us to recalculate your monthly contribution toward the cost of your care (NAMI).

Your monthly income for cost of care changed from $ 637 to $ 687, effective January 1, 1999 due to an increase in your pension.

Because this income change was not budgeted for 5 month(s), we are adjusting the amount you are required to contribute in the future toward the cost of your care. The following is an explanation of how we calculated the adjustment in your contribution for the periods indicated:

A. Your Revised NAMI is $ 687

B. Your Previous NAMI was $ 637

C. The Difference is $ 50

D. The Number of Months for which this income difference was not budgeted is 5 month(s) (From Jan. To May)

E. Total Amount of the Income Adjustment is $ 250

In order to make this adjustment, the total monthly income contribution required towards the cost of care will INCREASE/DECREASE from $ 637 to $ 937 effective June 1, 1999; and your monthly income contribution effective N/A will be $ N/A. Starting July 1, 1999 your monthly income contribution will be $ 687.

The LAW(S) AND/OR REGULATION(S) which allow us to do this is Section 366 of the Social Services Law and 18 NYCRR 360-4.9, 360-4.3 and 360-4.10.

The enclosed budget worksheet(s) explains these calculations.

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call Bell Atlantic Telephone, toll-free at 1-800-555-5000

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

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

cc: _____
Name of Medical Facility

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 give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. 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. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for a 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:*** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island):** (212) 417-8550.

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 852-4868.

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

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

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County:** (518) 474-8781

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

OR

(2) ***Writing:*** *By sending a copy of this notice completed, to the Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.*

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

_____

_____

_____

Signature of Client: _____ DATE: _____

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

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date of the action 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 on the top of the front of this notice.

☐ 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 top of the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we 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 us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the 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 the front of this notice or write to us at the address printed at the top of the front of this notice.

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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 information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We were recently informed of a change in your income and/or circumstances which requires us to recalculate your monthly contribution toward the cost of your care (NAMI).

Your monthly income for cost of care changed from $_____ to $_____, effective _____ due to _____.

Because this income change was not budgeted for _____ month(s), we are adjusting the amount you are required to contribute in the future toward the cost of your care. The following is an explanation of how we calculated the adjustment in your contribution for the periods indicated:

A. Your Revised NAMI is $_____

B. Your Previous NAMI was $_____

C. The Difference is $_____

D. The Number of Months for which this income difference was not budgeted is _____ month(s)
(From _____ To _____)

E. Total Amount of the Income Adjustment is $_____

In order to make this adjustment, the total monthly income contribution required towards the cost of care will INCREASE/DECREASE from $_____ to $_____ effective_____; and your monthly income contribution effective _____ will be $_____. Starting _____your monthly income contribution will be $_____.

The LAW(S) AND/OR REGULATION(S) which allow us to do this is Section 366 of the Social Services Law and 18 NYCRR 360-4.9, 360-4.3 and 360-4.10.

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

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If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 852-4868.**

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

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

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781**

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

OR

(2) *Writing: By sending a copy of this notice completed, to the Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.*

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

_____

_____

_____

Signature of Client: _____ DATE: _____

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

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date of the action 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 on the top of the front of this notice.

☐ 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 top of the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we 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 us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the 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 the front of this notice or write to us at the address printed at the top of the front of this notice.

ATTACHMENT IV

LDSS-4021 (Rev 8/98)

MA Only

NOTICE OF INTENT TO CHANGE THE CONTRIBUTION TOWARD CHRONIC CARE COSTS

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	CIN 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 information _____

OFFICE NO	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO

This notice is to inform you that this Department has recalculated the contribution required toward the cost of care for the individual named above as follows:

Previous Calculation		INCOME	New Calculation	
From _____ To _____			From _____ To _____	
Gross Monthly Income	$_____		Gross Monthly Income	$_____
Deductions	-_____		Deductions	-_____
Net Monthly Income	$_____		Net Monthly Income	$_____
Income Allowance (Personal Needs Allowance/MA Level)	-_____		Income Allowance (Personal Needs Allowance)	-_____
Contribution to Community Spouse, Family Member Allowance(s) or Dependent Household Member(s)	-_____		Contribution to Community Spouse, Family Member Allowance(s) or Dependent Household Member(s)	-_____
Cost of Medical/Remedial Care	-_____		Cost of Medical/Remedial Care	-_____
Remaining Available Monthly Income	=_____		Remaining Available Monthly Income	=_____
Contribution from Spouse	+_____		Contribution from Spouse	+_____
Total Income Contribution Per Mo.	$_____		Total Income Contribution Per Mo.	$_____
			Payable to: _____	

NOTE: Your monthly income contribution is based on a projection of income expected to be received. Adjustments will be made if your income or circumstances change.

Previous Calculation		RESOURCES	New Calculation	
Countable Resources	$_____		Countable Resources	$_____
Medical Assistance Level	-_____		Medical Assistance Level	-_____
Excess Resources	=_____		Excess Resources	=_____

Based on these calculations the monthly income contribution required towards the cost of care will:

☐ INCREASE from $_____ to $ _____.

☐ DECREASE from $_____ to $ _____.

☐ NOT CHANGE Your monthly income contribution continues to be $_____

In addition to any income contribution, $_____ of excess resources must be contributed toward the cost of care for the month of _____.

This change is effective _____ and is being made as a result of:

_____

_____

_____

The LAW(S) AND/OR REGULATION(S) which allows us to do this is Section 366 of the Social Services Law and 18 NYCRR 360-4.9, 360-4.3(f) and 360-4.10.

The enclosed budget worksheet(s) explains these calculations.

ATTENTION: Persons receiving Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE, call Bell Atlantic Telephone, toll-free at 1-800-555-5000

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

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

Enclosure

cc _____

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 give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. 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. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for a 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:* (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island):** (212) 417-8550.

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 852-4868.

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

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

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County:** (518) 474-8781

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

OR

(2) *Writing: By sending a copy of this notice completed, to the Office of Administrative Hearings, Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.*

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

_____

_____

_____

Signature of Client: _____ DATE: _____

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

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date of the action 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 on the top of the front of this notice.

☐ 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 top of the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we 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 us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the 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 the front of this notice or write to us at the address printed at the top of the front of this notice.

LDSS-4022 (Rev. 5/99)

ATTACHMENT III

NOTICE OF INTENT TO ESTABLISH A LIABILITY TOWARD CHRONIC CARE

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
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 information _____

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This Department has made a decision concerning eligibility under the Medical Assistance Program of the individual named above, who has been determined to be residing in a medical institution on a permanent basis. (If the individual was previously in receipt of full Medical Assistance coverage or Medical Assistance coverage subject to a spenddown amount of $ _____, the required contribution towards institutional costs is explained below.)

Date of Application: _____

Date of Institutionalization: _____

Date of Chronic Care Status: _____

We have calculated the total **monthly** contribution toward the cost of this individual's care for the periods indicated, as follows:

INCOME

From _____ To _____		From _____ To _____	
Gross Monthly Income	$ _____	Gross Monthly Income	$ _____
Deductions	– _____	Deductions	– _____
Income Allowance (Medical Assistance Level)	– _____	Income Allowance (Personal Needs Level)	– _____
Contribution to Community Spouse	– _____	Contribution to Community Spouse	– _____
Family Member Allowance(s), or Dependent Household Member(s)	– _____	Family Member Allowance(s), or Dependent Household Member(s)	– _____
Cost of Medical/Remedial Care	– _____	Cost of Medical/Remedial Care	– _____
Remaining Available Monthly Income	= _____	Remaining Available Monthly Income	= _____
Contribution from Spouse	+ _____	Contribution from Spouse	+ _____
Total Income Contribution Per Mo.	$ _____	Total Income Contribution Per Mo.	$ _____
Payable to: _____		Payable to: _____	

NOTE: Your monthly income contribution is based on a projection of income expected to be received. Adjustments will be made if your income or circumstances change.

RESOURCES

Resources, if any, must also be considered in calculating your eligibility.

Countable Resources	$ _____
Medical Assistance Level	– _____
Excess Resources	= _____
Medical Bills Used to Reduce Excess Resources	– _____
Remaining Excess Resources	$ _____

In addition to any income contribution(s) the remaining $ _____ of excess resources must be contributed toward the cost of care during the month of _____.

The Medical Assistance Program will pay any additional covered institutionalized costs during the authorized period.

The LAW(S) and/or REGULATION(S) which allows us to do this is Section 366 of the Social Services Law and 18 NYCRR 360-4.9, 360-4.3(f) and 360-4.10.

The enclosed budget worksheet(s) explains these calculations.

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

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION.

Enclosure

cc: _____

NAME OF MEDICAL FACILITY

NOTICE OF INTENT TO ESTABLISH A LIABILITY TOWARD CHRONIC CARE

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 a wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. 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. Read below for fair hearing information.

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

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

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

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

OR

(2) **Writing:** By sending 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.

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

_____

_____

Name: _____ Case Number: _____

Address: _____

Signature of Client: _____ Date: _____

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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.