

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NOTICE OF DECISION – DENIAL OF WAIVER SERVICE(S)

BRIDGES TO HEALTH (B2H) HOME & COMMUNITY BASED SERVICES MEDICAID WAIVER PROGRAM

CHILD'S NAME (LAST, FIRST, MI.):				
CHILD'S ADDRESS:				
CITY:		STATE:		ZIP CODE:
DATE OF BIRTH:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICAID CIN #:	DATE OF NOTICE:	EFFECTIVE DATE:
B2H WAIVER TYPE (Check one only) <input type="checkbox"/> B2H Serious Emotional Disturbance (SED) Waiver <input type="checkbox"/> B2H Developmental Disabilities (DD) Waiver <input type="checkbox"/> B2H Medically Fragile (MedF) Waiver				

DENIAL OF WAIVER SERVICE:

This is to inform you that your request for _____ in the B2H Medicaid Waiver
WAIVER SERVICE
 Program has been **DENIED** as of the effective date.

This is to inform you that your request for _____ in the B2H Medicaid Waiver
WAIVER SERVICE
 Program has been **DENIED** as of the effective date.

This is to inform you that your request for _____ in the B2H Medicaid Waiver
WAIVER SERVICE
 Program has been **DENIED** as of the effective date.

Reason(s) for Denial:

New York State Social Services Law Section 366.12 authorizes New York State Office of Children and Family Services (NYS OCFS) and New York State Department of Health (NYS DOH) to develop and implement home and community based service waivers pursuant to Section 1915 of the Federal Social Security Act.				
<input type="checkbox"/> LOCAL DEPARTMENT OF SOCIAL SERVICES (LDSS) OR <input type="checkbox"/> DIVISION OF JUVENILE JUSTICE AND OPPORTUNITIES FOR YOUTH (DJJJOY) CONTACT INFO (Check One)				
CONTACT'S NAME:		CONTACT'S SIGNATURE: X		DATE:
CONTACT'S TITLE:			PHONE #:	
CONTACT'S ADDRESS:		CITY:	COUNTY:	STATE: ZIP CODE:

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE FRONT AND BACK OF THIS NOTICE TO FIND OUT HOW YOU REQUEST A CONFERENCE AND/OR A FAIR HEARING.

RIGHT TO A CONFERENCE: You may have a conference with LDSS/DJJJOY staff to review these actions. If you want a conference you should ask for one as soon as possible. At the conference, if the LDSS/DJJJOY staff discovers that the wrong decision has been made, or if, because of information you provide, the LDSS/DJJJOY decides to change the decision, you will receive a new Notice of Decision. You may ask for a conference by calling or writing to the LDSS/DJJJOY at the telephone number and address listed above on 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 the page 2 for Fair Hearing information.

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CHILD'S NAME (LAST, FIRST, MI.):	MEDICAID CIN #:
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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 participants 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 (This is the deadline even if you ask for a conference with us).

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, pay stubs, receipts, child care bills, medical verification, letters, etc. that may be helpful in presenting your case.

I want a Fair Hearing. The decision is wrong because _____

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".

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 the LDSS/DJJOY, 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 LDSS/DJJOY, they will provide you with free copies of other documents from your file, which you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call or write to the LDSS/DJJOY 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 case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call or write the LDSS/DJJOY at the telephone number and address listed on the front page of this Notice.

Print Name: _____ Client Identification Number (CIN) _____

Address: _____ Telephone Number: _____

Signature: **X** _____ Date: _____

Original – Child/Medical Consenter; **Copy** – Local Department of Social Services or Division of Juvenile Justice and Opportunities for Youth, Health Care Integration Agency, Case Planning Agency, Caregiver