APPENDIX H

NOTICE OF REDUCTION OF PERSONAL CARE SERVICES/HOME ATTENDANT SERVICE
UNDER THE MEDICAL ASSISTANCE PROGRAM
FOR FAILURE TO COMPLY WITH REASSESSMENT REQUIREMENTS

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CEN
CASE NUMBER	CIN NUMBER	
CASE NAME AND ADDRESS		
		GENERAL TELEPHONE No FOR QUESTIONS OR Agency Conference Fair Hearing Information and assistance Record Access Legal Assistance Information
Office No.	Unit No. / Worker No.	Unit or Worker Name

Effective _____, your personal care services/home attendant services
REDUCED FROM:

_____hours per day, _____days per week (weekdays) and/or

_____hours per day, _____days per week (weekends and/or weekdays)

TO: 156 HOURS PER MONTH.

Your authorization period ends _____.

We intend to take this action because you refused to cooperate with the scheduling and
care assessment requirements and the social services district was unable to reassess you
services/home attendant services. As you were notified by letter, your failure to c
reduction of your services. We have also determined that your reduction in services w
health and safety.

This decision is based on Section 367-o of the Social Services Law and Department Regulation 18 NYCRR 505.14.

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

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a confe
one as soon as possible. At the conference, if we discover that we made the wrong d
information you provide, we determine to change our decision , we will take corrective act
notice. You may ask for a conference by calling us at the number at the top of this pa
request to us at the address listed at the top of this page of this notice. This number is
conference. It is not the way you request a fair hearing. If you ask for a conference you are still en
fair hearing. If you want to have your services continue unchanged (aid continuing) until
decision, you must request a fair hearing in the way described below. A request for a
result in continuation of services. Read below for fair hearing information.

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 a
You have the right to be represented by legal counsel, a relative, a friend or othe
yourself. At the hearing you , your attorney or other representative will have the opportur
oral evidence to demonstrate why the action should not be taken, as well as an opportunity t
appear at the hearing. Also, you have a right to bring witnesses to speak in your favor.
hearing any documents such as this notice, medical bills, medical verification, letters, et
presenting your case.

CONTINUING YOUR SERVICES: If you request a fair hearing before the effective date stated in
continue to receive your services unchanged until the fair hearing decision is issued. Howe
hearing, we may recover the cost of any Personal Care Services that you should not have rec
avoid this possibility, check the box to indicate that you do not want your aid continued,
with your hearing request. If you do check the box, the action described above will be ta
listed on the first page of this notice.

+--+
+--- I agree to have the action taken on my Personal Care Services, as described in
issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assista
local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aic
by checking your Yellow Pages under "Lawyers" or by calling the number indicated at the top

ACCESS TO RECORDS/INFORMATION: You have the right to review your case record. Upon your requ
free copies of documents which we will present into evidence at the fair hearing. Also, u
right to free copies of other documents from your case record. Call the number indicated c
notice, or send a written request to us at the address listed at the top of this notice.

If you want additional information about your case, how to request a fair hearing, how t
file and/or additional copies of documents, you may call the number indicated on the first
write us at the address listed at the top of this notice.

APPENDIX J

NOTICE OF OUTCOME OF PERSONAL CARE SERVICES/HOME ATTENDANT SERVICE
UNDER THE MEDICAL ASSISTANCE PROGRAM
DUE TO REASSESSMENT USING NEW HOME CARE ASSESSMENT INSTRUMENT

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CEN
CASE NUMBER	CIN NUMBER	
CASE NAME AND ADDRESS		
		GENERAL TELEPHONE No FOR QUESTIONS OR Agency Conference Fair Hearing Information and assistance Record Access Legal Assistance Information
Office No.	Unit No. / Worker No.	Unit or Worker Name

Your need for Personal Care Services/Home Attendant Services was reassesed using a r
instrument and the outcome is identifed in the box checked below. This notice is ef
Your authorization period ends _____.

+----+ AUTHORIZED AT THE SAME LEVEL
+----+

+----+ REDUCED FROM: +----+ INCREASED FROM:
+----+ +----+

_____hours per day, _____days per week (weekdays) and/or

_____hours per day, _____days per week (weekends and/or weekdays)

TO:

_____hours per day, _____days per week (weekdays) and/or

_____hours per day, _____days per week (weekends and/or weekdays)

+----+ DISCONTINUED
+----+

WE INTEND TO TAKE THE ACTION CHECKED ABOVE BECAUSE THE NEW HOME CARE ASSESSM
THAT:_____
_____
_____

IF WE INTEND TO DISCONTINUE YOUR PERSONAL CARE SERVICES/HOME ATTENDANT SERVICES, BASED
CARE ASSESSMENT INSTRUMENT, WE DETERMINED THAT YOUR CARE NEEDS REQUIRE A DIFFERENT LEVEL
CARE SERVICES. WE HAVE REFERRED YOUR SERVICE REQUEST TO: _____

HOWEVER, THE PERSONAL CARE SERVICES THAT YOU ARE CURRENTLY RECEIVING WILL CONTINUE UNTI