NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Notice of Determination for Disenrollment in the New York State Health Home Program

Notice Date _____ CIN Number _____

Effective Date (10-day Notice Required) _____

Health Home

Name Community Health Connections

Address 1300 Massachusetts Avenue; Troy, NY 12180

General Telephone Number for Questions or Help 518-271-3301

Member

Name _____

Parent, Legal Guardian, Legally Authorized Representative, if any _____

Address _____

This is to advise you that effective _____ this agency _____ will
Date Name of Health Home

Disenroll you from the Health Home Program.

You do not meet the criteria necessary for continued enrollment and you are being disenrolled from the Health Home Program, as of the effective date listed above, for the following reason(s):

- ☐ You no longer meet the Health Home chronic condition eligibility criteria. You must have either:
  - Two or more chronic condition OR
  - One single qualifying chronic condition (see list of single qualifying conditions on page 3 section A)
- ☐ You no longer have the appropriate type of Medicaid Coverage for Health Home Services.
- ☐ You do not require Health Home Care Management Services because you no longer meet the appropriateness criteria listed below on page three (3), section B.
- ☐ You currently reside in an excluded setting (e.g., Residential Treatment Facility, Nursing Home, Incarceration etc.).
- ☐ You have currently met all of the non-maintenance needs and goals outlined in your Plan of Care.
- ☐ You have moved out of New York State.
- ☐ You can no longer be served due to issues that affect your safety, health and welfare or that of the care management staff.
- ☐ You are concurrently eligible or enrolled, along with your caregiver/guardian in another Health Home.
- ☐ You have disengaged from Health Home Care Management Services and cannot be located or contacted for reengagement.
- ☐ Other (please specify): _____

This action is taken under NYS SSL 365-l

Health Home Representative

Signature: X _____

IF YOU DO NOT AGREE WITH THIS DECISION, YOU CAN ASK FOR A CONFERENCE, A FAIR HEARING, OR BOTH. PLEASE READ THE 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 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 inform you in writing. You may ask for a conference by calling the number listed on the first page of this Notice of Determination or by sending a written request to us at the address listed at the top of the first page of this Notice of Determination. 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. You must request a fair hearing in the way described below. Also, if you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, please be sure to read and complete the section below entitled, '**CONTINUING YOUR BENEFITS**'.

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: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); OR

2) Fax: Send a copy of this notice to fax no. (518) 473-6735; OR

3) On-Line: Complete and send the online request form at: http://www.otda.ny.gov/oah/forms.asp; OR

4) Write: Send 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.

5) **Walk In (New York City):**
Office of Temporary and Disability Assistance
Office of Administrative Hearing
5 Beaver Street,
New York, New York 10004

Walk In (Albany):
Office of Temporary and Disability Assistance
Office of Administrative Hearing
40 N. Pearl Street
Albany, New York 12201

6) Speech and Hearing Impaired:
Contact the New York Relay Service at 711 or 1-800-622-1220.
Request that the operator call 877-502-6155. Service at this number will only be provided to callers using TDD equipment.

☐ I want a Fair Hearing. This action is wrong because: _____

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, health care bills, heating bills, medical verification, doctor's letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated 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 above.

☐ 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 first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, the Health Home will send you a copy of the evidence packet upon your request. The evidence packet contains information the Health Home used to make their decision about your Health Home enrollment, which will be provided to the hearing officer to explain their decision. If you do not get your evidence packet by the week before your hearing, call us at the telephone number listed at the top of page 1 of this Notice of Determination and ask for it. If there is not enough time to mail the evidence packet to you, the Health Home will bring a copy of it to you at the hearing.

You have the right to look at your case file. If you call us ahead of time at the telephone number listed at the top of page 1 of this Notice of Determination or write to us within a reasonable time before the date of the hearing, we will provide you free copies of other documents from your file which you think you may need to prepare for your 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 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.

Print Name: _____ Client Identification Number (CIN): _____

Address: _____ Telephone Number: _____

Signature: X _____ Date: _____

Original – Medicaid Member/Parent/Guardian/Legally Authorized Representative

Copy as Applicable – Quality Management Specialist (QMS) Local Department of Social Services or Division of Juvenile Justice and Opportunities for Youth, Health Care Integration Agency, Case Planning Agency, Caregiver, Voluntary Foster Care Agency, Medical Consenter, Developmental Disabilities Regional Office (DDRO)

This document is available in other languages. This notice can be read to you in another language.

Notice of Determination for Disenrollment in the New York State Health Home Program

A. Health Home eligibility criteria includes two or more chronic conditions OR one single qualifying condition. The list of single qualifying conditions is as follows:

HIV/AIDS (Adults and Children) or
Serious Mental Illness (SMI) (Adults only) or
Sickle Cell Disease (SCD) or
Serious Emotional Disturbances (SED) (Children only) or
Complex Trauma (Children only) or
Intellectual Disability (OPWDD) or
Cerebral Palsy (OPWDD) or
Epilepsy (OPWDD) or
Neurological Impairment (OPWDD) or
Familia Dysautonomia (OPWDD) or
Prader-Willi Syndrome (OPWDD) or
Autism (OPWDD)

B. Appropriateness Criteria for Continued Eligibility and Enrollment in the NYS Health Home Program are:

For ADULTS only

- Current H-Code in the Electronic New York State Medicaid System (eMedNY).
- Current Performance Opportunity Project (POP) flag in the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES).
- Current Quality or Health Home Plus (HH+) flag in Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or equivalent from Regional Health Information Organization (RHIO) or Managed Care Organization (MCO).
- Currently homeless (HUD 1, 2, or 4) or does not have stable living arrangement in the last three (3) months.
- Change in guardianship/caregiver in the past three (3) months.
- Cannot access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc.
- Current Intimate Partner Violence.
- Does not have primary care provider and/or any specialist needed to treat your chronic or single-qualifying condition.
- Report of treatment non-adherence and has had difficulty managing medications within the last three (3) months.
- Current Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) flag related to non-adherence or equivalent from Regional Health Information Organization (RHIO) or Managed Care Organization (MCO).
- Released from inpatient Medical, Psych, Crisis Stabilization, Residential Treatment Setting, or Detox within the last three (3) months.
- Released from Jail/Prison or other justice program within the last three (3) months.
- Preventable or unnecessary hospitalizations or Emergency Room visits related to your chronic or single qualifying condition.
- Has safety concerns in your environment or community and does not have an appropriate safety plan in place.
- Been a danger to themselves or others within the last six (6) months.
- Required a crisis management response for your mental health diagnosis.
- Unable to meet and maintain your Substance Use Disorder goals.
- Experiencing Intimate Partner Violence and does not have a current safety plan in place.
- Not following the health/behavioral health requirements of your Parole/Probation over the last three (3) months.
- Does not know who your core medical/behavioral health providers are or how to contact them.
- Unable to manage Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

For CHILDREN only

- Current K1-code in EMEDNY (Children's Waiver Enrolled)
- Involved with mandated preventive services or referred within the last six (6) months from Child Protective Services/Preventive Services Program, County Local Departments of Social Services, Administration for Children's Services (for New York City), Special Education Program, and Schools.
- Inpatient/Emergency Department/psychiatric stay within the last six (6) months.
- Out of home placement within the last six (6) months.
- Diagnosed with a terminal illness/condition within the last six (6) months.
- Received an initial Disability Determination within the last six (6) months.
- Released from Jail/Prison or other justice program within the last six (6) months.
- Unable to schedule and keep healthcare appointments in the last three (3) months.
- Does not have a primary care provider and/or any specialist to treat your chronic or single-qualifying condition.
- Has not seen your provider (e.g., PCP, BH) within the last year.
- Experiencing current Intimate Partner/ current Family Violence in the home.

- Experiencing food insecurity due to financial limitations or ability to shop or access food site, dietary restrictions, and needs related benefits.
- Currently homeless and without a stable living arraignment.
- Change in guardianship/caregiver within the last six (6) months.
- Individual or caregiver needs and does not have a necessary entitlement(s).
- Non-adhere to treatments and medications within the last three (3) months.
- Current Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) flag related to non-adherence or equivalent from Regional Health Information Organization (RHIO) or Managed Care Organization (MCO).
- Direct referral from Managed Care Organization (MCO), Local Government Units (LGU), Single Point of Access (SPOA), or county Local Department of Social Services.