NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

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

Notice Date ______________________ CIN Number ______________________

Effective Date ______________________

Health Home

Name ______________________

Address ______________________

General Telephone Number for Questions or Help ______________________

Member

Name ______________________

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

Address ______________________

This is to advise you that effective ______________ (Date) this agency ______________________ (Name of Health Home) has

Denied your enrollment into the Health Home Program

You do not meet the criteria necessary for enrollment in the Health Home program due to the following reason(s):

- ☐ You do not meet the Health Home chronic condition eligibility criteria. You must have either:
  - Two or more chronic conditions OR
  - One single qualifying chronic condition (see list of single qualifying conditions listed below on page 3, section A.)
- ☐ You do not have the appropriate type of Medicaid Coverage for Health Home Services.
- ☐ You do not require Health Home Care Management Services because you do not meet any of the appropriateness criteria (see list of appropriateness criteria listed below on page 3, section B).
- ☐ You currently reside in an excluded setting (Residential Treatment Facility, Nursing Home, Hospital, Incarceration etc.)
- ☐ 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 PAGE 2 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.

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.

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, at no cost. 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

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

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
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)
Familia Dysautonomia (OPWDD) or
Prader-Willi Syndrome (OPWDD) or
Autism (OPWDD)

B. The Appropriateness Criteria needed for 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).
- Does not have a primary care provider and/or any specialist for your chronic or single-qualifying condition.
- Inpatient, Emergency Department, Crisis Stabilization, Residential Treatment Setting, Psych, or Detox stay within the last three (3) months.
- Released from Jail/Prison or other justice program within the last three (3) months.
- 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 three (3) months.
- Needs and does not have a necessary entitlement(s).
- Recent or ongoing institutionalization or placement of primary support person within the last three (3) months and there is no other person to provide the same level of support.
- 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.
- Direct referral from Adult Protective Services
- Has an established relationship with a provider but has not seen them in the last year: Applicable to Primary Care Provider, mental health provider, substance use provider, or provider to treat their Single Qualifying Condition (Complex Trauma, Sickle Cell Disease, Serious Emotional Disturbance/Serious Mental Illness, or HIV) or physical disability related to a neurologic, muscular, or neuromuscular condition.

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 Loc al 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 for your chronic or single-qualifying condition.
- Has not seen their 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.
- Concurrently Health Home appropriate due to caregiver/guardian enrolled in Health Home.
- 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.