

**NOTICE OF DECISION TO DENY
OR DISCONTINUE HOME CARE SERVICES
FROM THE ASSISTED LIVING PROGRAM (ALP)**

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS
CASE NUMBER	CIN NUMBER	
CASE NAME AND ADDRESS		
+---	---	GENERAL TELEPHONE
+---	---	OR Agency Conference Fair Hearing and assistance Record Access Legal Assistance
Office No.	Unit No.	Worker No.
Unit or Worker No.		

Your need for Home Care Services from the Assisted Living Program (ALP) has been determined that your request is:

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+++ DENIED

Your request for Home Care Services from the Assisted Living Program (ALP) is:

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+++ DISCONTINUED

Your Home Care Services from the Assisted Living Program (ALP) are being discontinued because:

We intend to discontinue your home care services from the Assisted Living Program (ALP). The home care services that you are currently receiving will continue until the services listed below become available. The discontinuance will not happen before:

Based on your current medical condition, you must be referred to the following services:

HOME CARE SERVICES FROM THE ASSISTED LIVING PROGRAM (ALP)-DENY OR DISCONTINUED

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want one as soon as possible. At the conference, if we discover that the information you provide, we determine to change our decision, we will give you notice. You may ask for a conference by calling us at the number on the written request to us at the address listed at the top of the first page or by asking for a conference. It is not the way you request a fair hearing. If you ask for a conference, you are not entitled to a fair hearing. If you want to have your benefits continued after a fair hearing decision, you must request a fair hearing in the way described below. A conference will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a fair hearing.

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

- If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens)
- If you live in: Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans
- If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Warren, Yates County: (716) 266-4868
- If you live in: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 487-4868
- If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Hamilton, Montgomery, Orange, Otsego, Putnam, Rensselaer, Saratoga, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester
- If you live in: Nassau or Suffolk: (516) 739-4868

OR

(2) Writing: By sending a copy of this notice completed, to the Fair Hearing Unit, Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy of this notice.

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

Signature of Client _____ Date _____

Address..... _____

Phone Number..... _____ Case Number _____

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 date, time and location of the hearing. You have the right to be represented by legal counsel, a relative or friend, or yourself. At the hearing you, your attorney or other representative will present oral evidence to demonstrate why the action should not be taken, as well as you may appear at the hearing. Also, you have a right to bring witnesses to support your case at the hearing any documents such as this notice, medical bills, medical verification, etc. When presenting your case.