RIGHT TO A CONFERENCE: You may have a conference to review this action. If you want a confer as soon as possible. At the conference, if we discover that we made the wrong decision or if provide we determine to change our decision, we will take corrective action and give you a ne conference by calling your worker or by sending a written request to your local social servic used only for asking for a conference. **It is not the way you request a fair hearing**. If you ask for a con still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid- fair hearing decision, you must request a fair hearing in the way described below. A request **not** result in continuation of benefits. Read below for fair hearing information.

FAIR HEARING REQUEST: These changes in your Medical Assistance coverage are based on a change right to have a fair hearing if you think we made a mistake about your date of birth or wheth program or HMO, but not just because you think the new law is unfair. The hearing officer at you do not have a right to a hearing or a continuation of Medical Assistance, if the only iss change in State law. You may request a State fair hearing by:

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

If you live in: **New York City** (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212)
If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County:** (716) 85
If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates** (716) 266-4868.
If you live in: **Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga** St. Lawrence, Tompkins or Tioga County: (315) 422-4868.
If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

OR

(2) Writing: By sending a copy of both pages of this notice, to the Fair Hearing Section, New Social Services, P.O. Box 1930, Albany, New York 12201. PLEASE KEEP A COPY FOR YOURSEL

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

Signature of Client_____Date_____Case #_____

Address: _____

Telephone # _____

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 anc have the right to be represented by legal counsel, a relative, a friend or other person or tc hearing you, your attorney or other representative will have the opportunity to present writt demonstrate why the action should not be taken, as well as an opportunity to question any per hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring such as this notice, and medical verification that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in to receive your benefits unchanged until the fair hearing decision is issued. However, if yc may recover the cost of any Medical Assistance benefits that you should not have received. I possibility, check the box below to indicate that you do not want your aid continued, and senc hearing request. If you do check the box , the action described above will be taken on the e

+--+ I agree to have the action taken on my Medical Assistance benefits, as described
+--+ prior to the issuance of the fair hearing decision.