



STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: September 12, 2016

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000007899

[REDACTED]

Dear [REDACTED],

On March 15, 2016, NY State of Health (NYSOH) issued an eligibility determination notice, stating that you were eligible for Medicaid for December 1, 2015 through February 29, 2016. You appealed this determination insofar as you were seeking to be found eligible for Medicaid during the month of November 2015.

On August 15, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for September 7, 2016, at 10:00 AM.

On September 7, 2016, a Hearing Officer placed two calls to the telephone number that you provided to NYSOH, at 10:01 a.m. and 10:11 a.m. On the second call attempt, a certified application counselor, [REDACTED], answered and requested to hold the hearing in your stead since you were allegedly incapacitated. However, since you were not available, no completed Designation of Authorized Representative form or Guardianship Order was available in your NYSOH account designating her as your Authorized Representative or legal guardian, she was unable to participate in the hearing.

Since you did not appear for your hearing as scheduled, we are dismissing your appeal.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-622-4886).

How does this Dismissal Affect My Eligibility?

The Appeals Unit of NYSOH will not review your appeal at this time.

If You Think Your Appeal Should Not Be Dismissed

If you think your appeal should not be dismissed, you can ask us to vacate (cancel) this dismissal. You must ask us, in writing, within 30 days of the date on this notice. In that writing, you must explain why you did not appear for your hearing as scheduled.

NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Appeal Identification Number

When communicating with NYSOH about this appeal, please refer to both the Appeal Identification Number and the Account ID at the top of this notice.

How to Contact NYSOH

You can contact NYSOH in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY – English: 1-800-662-1220) (TTY – Spanish: 1-877-622-4886).

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations § 155.530.

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A Copy of this Notice of Dismissal Has Been Provided To:



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