



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

## NOTICE OF DISMISSAL – FAILURE TO APPEAR

Notice Date: January 3, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000010231

[REDACTED]

[REDACTED],

On June 14, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, stating that your son was eligible to enroll in Child Health Plus, effective July 1, 2016. You appealed this determination.

On December 6, 2016, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for December 21, 2016 at 10:00 AM.

On December 21, 2016, a Hearing Officer placed a call to the telephone number that you provided to NYSOH, at 10:00 AM. You answered the call and requested that the hearing be postponed because you were not aware that it was scheduled for that day. You confirmed your identity and were sworn in. While under oath, you waived the right to a written notice of your new hearing date, and agreed to the rescheduling of the hearing to December 29, 2016 at 10:00 AM. Also while under oath, you acknowledged that you understood your appeal would be dismissed if you did not answer the call from the Hearing Officer on December 29, 2016.

On December 29, 2016, the Hearing Officer placed three calls to the telephone number that you provided to NYSOH, at 10:00 AM, 10:15 AM, and 10:30 AM. But was unable to reach you.

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

## **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 after 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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