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

# NOTICE OF DISMISSAL – UNTIMELY APPEAL REQUEST

Notice Date: January 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000011577

On March 15, 2016, New York State of Health (NYSOH) issued an eligibility determination notice stating that your child was eligible to enroll in Child Health Plus for a cost of $45.00 per month, effective as of April 1, 2016.

On March 15, 2016, NYSOH issued an enrollment notice confirming that as of March 14, 2016, your child was enrolled in Child Health Plus plan with a monthly premium of $45.00.

The record indicates that (1) you requested an appeal insofar as the amount of financial assistance your child was determined eligible to receive for the period of April 1, 2016 through July 31, 2016, and (2) a formal complaint and appeal were filed regarding this issue on August 19, 2016.

## Why Your Appeal Request Is Not Valid

Applicants and enrollees must request a hearing within sixty (60) days from the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

For an appeal to have been valid on the issue of your child's financial assistance as of April 1, 2016, as addressed in the March 15, 2016 notices, an appeal should have been filed by May 14, 2016. According to the credible evidence in the record, a complaint and formal appeal was not filed until August 18, 2016.

This date exceeds the 60 days from the March 15, 2016 eligibility determination notice.

Therefore, your appeal request of the March 15, 2016 eligibility determination notice was not timely, and your appeal on the issue of the amount of financial assistance your child was eligible to receive effective April 1, 2016, is DISMISSED.

## How does this Dismissal Affect Your Eligibility?

This decision does not change your child's eligibility for or enrollment in health insurance through NYSOH.

## If You Think Your Appeal Should Not Be Dismissed

If you think your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. In that writing, you must explain why you think this dismissal should be vacated.

If you ask us in writing to vacate this dismissal, NYSOH's Appeals Unit will review your request and send you a decision on that request.

If we deny your request to vacate this dismissal, we will tell you that in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed. No further action will be taken on it by NYSOH.

## Appeal Identification Number

When communicating with NYSOH about this appeal, please reference Appeal Identification Number at the top of this notice.

## How to Contact NYSOH

You can contact us 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

## Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.530.

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