



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

## NOTICE OF DISMISSAL

Notice Date: March 09, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013609

[REDACTED]

Dear [REDACTED]

On November 30, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination, stating that you and your spouse were eligible to purchase a qualified health plan at full cost, effective January 1, 2017. The notice stated your information would be sent to the local Department of Social Services to determine your eligibility for Medicaid on a different basis. You appealed this determination.

On February 14, 2017, NYSOH issued a Notice of Hearing to advise you that the hearing you requested was scheduled for March 6, 2017, at 10:00 a.m.

A Hearing Officer called you at 10:00 a.m. on March 6, 2017 with the aid of Chinese interpreter [REDACTED]. Although an individual answered the call, they refused to identify themselves, and would not be sworn in so that further personal information regarding your account could be provided to the individual. The individual asked whether the Hearing Officer was selling something or was with the government. The Hearing Officer responded they were from NYSOH Appeals Unit and was calling regarding the appeal hearing which was scheduled for the day at 10:00 a.m. The Hearing Officer explained and identified the Notice of Hearing issued. The individual then stated more information would need to be sent to them in order to speak any further to the Hearing Officer. The individual then ended the call.

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).

Since your hearing did not go forward 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, or cancel, this dismissal. You must ask us, in writing, within 30 of the date on this notice. In that writing, you must explain why your hearing did not go forward 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 NY State of Health number 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

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## **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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