



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

## Notice of Decision

Decision Date: September 12, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000019587

[REDACTED]

Dear [REDACTED],

On September 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 7, 2017 eligibility determination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health Account ID at the top of this notice.

### Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

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: 1-877-662-4886).

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## Decision

Decision Date: September 12, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000019587



## Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Was your daughter eligible for Medicaid through NY State of Health (NYSOH) in the month of April 2017?

## Procedural History

On June 6, 2017, you submitted an updated application for financial assistance with health insurance and indicated that you were seeking help for paying for medical bills for May 2017 on behalf of your daughter.

Also on June 6, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination notice insofar as it denied retroactive Medicaid for the month of May 2017.

On June 7, 2017, NYSOH issued a notice of eligibility determination stating that your daughter was not eligible for Medicaid from May 1, 2017 through May 31, 2017 because the program she was eligible for cannot pay for any care she received in the past.

Also on June 7, 2017, NYSOH issued a notice of eligibility determination stating that your daughter was eligible for Child Health Plus with a monthly premium of \$9.00, effective July 1, 2017.

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On September 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you clarified that you are seeking retroactive Medicaid on behalf of your daughter for the month of April 2017, not May 2017. The record was developed during the hearing and closed at the end of the hearing.

## **Findings of Fact**

A review of the record supports the following findings of fact:

- 1) You testified that you are seeking Medicaid for your daughter from April 1, 2017 through April 30, 2017.
- 2) You testified that you expect to file your 2017 federal income tax return as head of household, and claim two dependents.
- 3) You submitted an application for financial assistance on June 6, 2017.
- 4) Your application submitted on June 6, 2017 states that your expected annual income is \$40,000.00.
- 5) You testified that this was correct at the time, based on the job that you were working, but that you started a new job in July 2017, and your income decreased.
- 6) You testified that, in April 2017, you were earning a gross income of between \$700.00 and \$800.00 a week, and were paid weekly, on Fridays.
- 7) It is noted that there were four Fridays in the month of April 2017.
- 8) You testified that you cannot provide paystubs for that position.
- 9) You testified that your daughter was in the [REDACTED] in April 2017, and that you have a [REDACTED] bill that you cannot afford to pay.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

## **Applicable Law and Regulations**

### Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the federal poverty level (FPL) for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1)).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is \$20,420.00 for a three-person household (82 Fed. Reg. 8831).

### Retroactive Medicaid

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of an initial application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 USCA § 1396A(34); 42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

## **Legal Analysis**

The issue under review is whether your daughter was eligible for retroactive Medicaid for the month of April 2017.

Your daughter is in a three-person household. You testified that you plan to file your taxes with a tax filing status of head of household, and claim two dependents on your tax return.

You submitted an application for financial assistance on June 6, 2017 and requested help in paying for medical bills for your daughter for May 2017. However, at the hearing, you clarified that you are actually seeking assistance with a medical bill for your daughter from the month of April 2017.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether or not that initial application resulted in Medicaid going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in April 2017, your child would have needed to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is \$2,621.00 per month. There is no indication in the record that your daughter would have been ineligible for Medicaid based on non-financial criteria during April 2017.

You testified that, in April 2017, you were working in a position where you earned a gross weekly income of between \$700.00 and \$800.00. You testified that you do not have any paystubs for this job, and would be unable to submit any documentation. However, based on your testimony, your monthly income in April 2017 would have been between \$2,800.00 and \$3,200.00.

Since a monthly income of \$2,800.00 is over the Medicaid monthly income limit for your daughter (\$2,621.00), your daughter would not have been eligible for Medicaid in the month of April 2017, even if you earned only \$700.00 a week.

Therefore, the June 7, 2017 eligibility determination stating that your daughter was not eligible for Medicaid in the month of May 2017 because the program she is eligible for cannot pay for any care received in the past is MODIFIED to state that your daughter was not eligible for Medicaid in the month of April 2017 because your monthly income was over the allowable monthly income limit for Medicaid.

## **Decision**

The June 7, 2017 eligibility determination is MODIFIED to state that your daughter was not eligible for Medicaid from April 1, 2017 through April 30, 2017 because your monthly income was over the allowable monthly income limit for Medicaid.

**Effective Date of this Decision:** September 12, 2017

## **How this Decision Affects Your Eligibility**

Your daughter was not eligible for Medicaid in the month of April 2017.

## **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:  
Health Insurance Marketplace  
Attn: Appeals  
465 Industrial Blvd.  
London, KY 40750-0061
- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

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: 1-877-662-4886).

## **If You Have Questions about this Decision (Customer Service Resources):**

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

## **Summary**

The June 7, 2017 eligibility determination is MODIFIED to state that your daughter was not eligible for Medicaid from April 1, 2017 through April 30, 2017 because your monthly income was over the allowable monthly income limit for Medicaid.

Your daughter was not eligible for Medicaid in the month of April 2017.

## **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.



**A Copy of this Decision Has Been Provided To:**



## Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

### Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

### 中文 (Traditional Chinese)

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

### Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

### 中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

### Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

### 한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

### Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

### العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

### বাংলা (Bengali)

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: 1-877-662-4886).

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

### **Français (French)**

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

### **हिंदी (Hindi)**

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया नि:शुल्क उपलब्ध करवा सकते हैं।

### **日本語 (Japanese)**

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

### **नेपाली (Nepali)**

यो एउटा महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

### **Polski (Polish)**

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

### **Twi (Twi)**

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ kasa a woka no ase ama wo kwa a wontua hwee.

### **(Urdu) اردو**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

### **Tiếng Việt (Vietnamese)**

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

### **אידיש (Yiddish)**

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען איר געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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