<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

It is urgent that we confirm your address.

Only people who live in our service area (<counties in which plan is available>) can be part of <plan name>. We need to confirm that you still live in our service area.

Please contact us by <30 days from date of this notice> to tell us your home address.

If you are no longer living in <counties in which plan is available>, you will no longer be able to get your Medicaid and Medicare services through <plan name>.

How to contact us:

* Callus at <toll-free phone number> (TTY: <toll-free TTY number>), OR
* Fill out the “Address Verification Form” and fax it to us at <fax number> or mail it in the enclosed, pre-paid envelope.

Please remember the six-month rule!

* You can stay in our plan if you are away from our service area for up to 6 months in a row.
* You cannot stay in our plan if:
  + You move and your new address is outside our service area;
  + You leave our service area for more than 6 months in a row.

You must also tell Social Security about your address change.

If you have moved and have not told the Social Security Administration your new address, please call them at the phone number in the enclosed List of Resources.

**If you need help understanding this letter or have questions about your rights,** please call the ombudsman office through the Independent Consumer Advocacy Network (ICAN) at the phone numbers in the enclosed List of Resources.

Thank you.

<Plan Name>

<Plan’s legal or marketing name> is a managed care plan that contracts with Medicare, the New York State Department of Health (Medicaid), and the Office for People With Developmental Disabilities to provide benefits to Participants through the Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration.

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <days and hours of operation>. The call is free. [This disclaimer must be placed in both English and all non-English languages that meet the Medicare and state thresholds for translation. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]

You can get this information for free in other formats, such as large print, braille, or audio. Call <toll-free number> and <TTY/TDD numbers> during <days and hours of operation>. The call is free.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 (TTY users, call 711) or online at icannys.org.

**List of Resources**

|  |  |  |
| --- | --- | --- |
| **<Plan Name>**  For questions about your plan coverage |  | Call: <toll-free number>  TTY users: <toll-free TTY number>  <days and hours of operation>  The call and the help are free.  Online: <website> |
| **New York Medicaid Choice**  For questions about the FIDA-IDD program and your Medicaid benefits |  | Call: 1-844-343-2433  TTY users: 1-888-329-1541  A free interpreter: 1-855-600-3432  Monday-Friday, 8:30 am – 8:00 pm  Saturday, 10:00 am – 6:00 pm  The call and the help are free.  Online: www.nymedicaidchoice.com |
| **Medicare**  For questions about your Medicare benefits |  | Call: 1-800-MEDICARE (1-800-633-4227)  TTY users: 1-877-486-2048  24 hours a day, 7 days a week  The call and the help are free.  Online: www.medicare.gov |
| **Social Security Administration**  To update your information |  | Call: 1-800-772-1213  TTY users: 1-800-325-0778  Monday-Friday, 7:00 am – 7:00 pm  The call and the help are free.  Online: www.ssa.gov |
| **Independent Consumer Advocacy Network (ICAN)**  For questions about your rights |  | Call: 1-844-614-8800 (TTY users, call 711)  A free interpreter: 1-844-614-8800  Monday-Friday, 8:00 am – 8:00 pm  The call and the help are free.  Online: www.icannys.org |

**Address Verification Form**

|  |
| --- |
| Name |

|  |  |  |  |
| --- | --- | --- | --- |
| What is your current HOME address? (This cannot be a P.O. box.) | | | |
| Address | | | | |
| City | | State | ZIP code | |
| County | Phone | | | |

What is your TEMPORARY address? (This cannot be a P.O. box.)

You may skip this section if you are currently living at your home address.

|  |  |  |  |
| --- | --- | --- | --- |
| Address | | | |
| City | | State | ZIP code |
| County | Phone | | |
| When did you begin living/staying at this address?  🞎🞎/🞎🞎/🞎🞎🞎🞎  (month/day/year) | When do you think you will go back to your home address?  🞎🞎/🞎🞎/🞎🞎🞎🞎  (month/day/year) | | |
| Where would you like to get your mail? | | | | |
| Address | | | | |
| City | | State | ZIP code | |

Send us the form in one of two ways:

1. Mail your completed form to <address> in the pre-paid envelope provided.
2. Fax your completed formto <fax number>.

**For more information,** visit <web address>. **If you have questions**, call <plan name> at <toll-free number>, <days and hours of operation>. The call is free.