



**ASSEMBLY COMMITTEE ON HEALTH
ASSEMBLY COMMITTEE ON CORRECTION**

NOTICE OF PUBLIC HEARING

SUBJECT: Healthcare in New York correctional facilities

PURPOSE: To examine health care issues in state and local correctional facilities, including: adequacy of care, treatment of communicable diseases, women's healthcare, administering medication, and long-term care; use of for-profit health care contractors; health care facility placements for inmates leaving incarceration; and potential Medicaid coverage for incarcerated individuals.

Albany

Monday, October 30, 2017
11:00 A.M.
Hearing Room C
Legislative Office Building

ORAL TESTIMONY BY INVITATION ONLY

There are approximately 50,000 people incarcerated in New York state prisons and 25,000 people in local jails, many at high risk for illnesses related to poverty and addiction. New York correctional facilities are required to provide healthcare to incarcerated individuals. Advocates have identified challenges to providing health care in these facilities including: the need to obtain a waiver from the Federal Government to utilize full Medicaid funding to pay for treatment to improve continuity of care upon release; staffing and quality control concerns; decentralized oversight of medical services in local correctional facilities; and the complexity of ensuring continuity of care when inmates are moved from one facility to another and following release; use of for-profit correctional medical companies; and adequacy of health care for women inmates.

Persons invited to participate in the hearing should complete and return the enclosed reply form as soon as possible. It is important that the reply form be fully completed and returned so that persons may be notified in the event of emergency postponement or cancellation.

Oral testimony will be limited to ten minutes. All testimony will be under oath. In preparing the order of witnesses, the Committees will attempt to accommodate individual requests to speak at particular times in view of special circumstances. These requests should be made on the attached reply form or communicated to Committee staff as early as possible.

Ten copies of any prepared testimony should be submitted at the hearing registration desk. The Committees would appreciate receiving prepared statements in advance.

In order to meet the needs of those with a disability, the Assembly, in accordance with its policy of non-discrimination on the basis of disability, as well as the 1990 Americans with Disabilities Act (ADA), has made its facilities and services available to all individuals with disabilities. For individuals with disabilities, accommodations will be provided, upon reasonable request, to afford such individuals access and admission to Assembly facilities and activities.

Richard N. Gottfried
Member of Assembly
Chair
Committee on Health

David I. Weprin
Member of Assembly
Chair
Committee on Correction

PUBLIC HEARING REPLY FORM

Persons invited to present testimony at the hearing on **Health Care in Correctional Facilities** are requested to complete this reply form as soon as possible, and mail, email or fax it to:

Kristin Zielinski
Committee Assistant
Assembly Program and Counsel
Room 442 - Capitol
Albany, New York 12248
Email: zielinskik@nyassembly.gov
Phone: (518) 455-4371
Fax: (518) 455-4693

- I have been invited and plan to attend the hearing on "Health Care in Correctional Facilities" to be conducted by the Assembly Committees on Health and Correction on October 30, 2017, in Albany, New York
- I plan to make a public statement at the hearing.

My statement will be limited to 10 minutes, and I will answer any questions which may arise. I will provide 10 copies of my prepared statement.

- I will address my remarks to the following subjects:

- I do not plan to attend the above hearing.
- I would like to be added to the Committee mailing list for notices and reports.
- I would like to be removed from the Committee mailing list.
- I will require assistance and/or handicapped accessibility information. **Please specify the type of assistance required:** _____

NAME: _____

TITLE: _____

ORGANIZATION: _____

ADDRESS: _____

E-MAIL: _____

TELEPHONE: _____

FAX TELEPHONE: _____