



Commonwealth of Massachusetts
Executive Office of Health
and Human Services
Office of Medicaid
www.mass.gov/masshealth

TAUNTON OFFICE
21 SPRING ST, SUITE 4
TAUNTON MA 02780-3400

MEC Tel: (800) 242-1340
MEC TTY: (888) 665-9997
MEC Fax: (508) 828-4611

Medicaid ID : [REDACTED]

570/D
MASS LAW REFORM INSTITUTE
c/o VICTORIA PULOS
99 CHAUNCY ST
BOSTON MA 02111-0000

Attn: MASS LAW REFORM INSTITUTE Re: Notice sent to [REDACTED]

Date: 08/11/2009 Notice: [REDACTED] SSN: [REDACTED]

Important! This health-care benefits notice tells you the decisions we have made about certain programs that you may be eligible for. Please read the whole notice to find out about your health-care benefits.

Commonwealth Care

Dear [REDACTED]

The Connector is ending Commonwealth Care coverage for the following member(s)
The coverage will end only for family members listed below.

Name	SSN/DOB	Coverage End Date
[REDACTED]	[REDACTED]	08/31/2009

Reason and Manual Citation

You are not eligible for the Commonwealth Care Health Insurance Program because you do not meet the immigration and citizenship requirements for Commonwealth Care. You may be eligible for Commonwealth Care if you send us proof of your immigration status or if there is a change to your status (see 956 CMR 3.05).

continued...

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If you have any questions about your eligibility for Commonwealth Care, please call the number at the top of this notice.

MassHealth

MassHealth has decided that the following members of your family are not eligible for MassHealth for the following reasons.

Name	SSN/DOB
[REDACTED]	[REDACTED]

Reason and Manual Citation

You do not meet the immigration requirements for any benefits other than MassHealth Limited, and you do not meet the requirements to get MassHealth Limited because your family income is too high or because you do not meet MassHealth disability rules, or you are not under age 19, or you are not a parent of a child under 19. 130 CMR 501.001 504.002 505.002 505.008

Call the phone number at the top of this notice if you have any questions about this notice. If you don't have a copy of the MassHealth booklet, please call to

request one. It has important information about MassHealth coverage and rules.

For information about appealing our decisions, see the Request for a Fair Hearing page of this notice.

Health Safety Net (formerly Uncompensated Care Pool (UCP))

The Commonwealth of Massachusetts has decided that the Health Safety Net may be able to pay for services that the individual(s) listed below get at a Massachusetts hospital or community health center. If you have other health insurance, that health insurance must be used first before the Health Safety Net will pay for any services you receive at a hospital or community health center. You may be charged copays and deductibles.

Name	Coverage	Family	Benefit
SSN	Type	Deductible	Effective Date
[REDACTED]	Health Safety Net	n/a	08/11/2009

Please get in touch with your hospital or community health center to find out what services you can get without having to pay bills.

You must tell MassHealth about certain changes that could affect your coverage. These include any changes in income, family size, employment, student status, disability status, health insurance, address, and immigration status. This will let us determine the most complete coverage you can get. Address changes are needed so you will get notices about your benefits. Once a change occurs, please report the change to MassHealth within 10 days or as soon as possible.

If you have questions about this Health Safety Net decision, please call the number at the top of this notice. If you do not agree with this Health Safety Net decision, you may contact the Massachusetts Division of Health Care Finance and Policy, Grievances, Two Boylston Street, Boston, MA 02116, or you can call them at 1-877-910-2100.

HOW TO ASK FOR A FAIR HEARING

Your Right to Appeal: If you disagree with the action by MassHealth, you have the right to appeal and ask for a fair hearing before an impartial hearing officer. The Board of Hearings must get your fair hearing request form no later than 30 calendar days from the date you got MassHealth's official written notice telling you of the action to be taken.

If you want to ask for a fair hearing because MassHealth did not take action on your application or on your request for service, MassHealth did not send you a written notice of the action to be taken, or a MassHealth employee's behavior toward you was coercive or improper, the Board of Hearings must get your fair hearing request form no later than 120 calendar days from the date of your application or your request for service, MassHealth's action, or the MassHealth employee's improper behavior.

How to Appeal: To ask for a fair hearing, fill out the fair hearing request form (be sure to fill out Section 11-Reason for Appeal) and send one copy with a copy of the MassHealth official written notice to: Board of Hearings, Office of Medicaid, 2 Boylston Street, Boston, MA 02116 or fax them to 617-210-5820. Please keep one copy of the fair hearing request form for your information.

If You Are Now Getting MassHealth: If the Board of Hearings gets your fair hearing request form before the date the action is taken or, if later, within 10 calendar days of the mailing date of MassHealth's written notice to you, you will keep getting MassHealth until a decision is made on your appeal. If you get MassHealth during your appeal, and then lose your appeal, you may have to pay MassHealth back for the cost of MassHealth benefits that you got during this time period. If you do not want to keep getting MassHealth during your appeal, please check Box A in Section III on the fair hearing request form. If you do not get MassHealth during your appeal, and then you win your appeal, MassHealth will restore your MassHealth benefits.

Date of Fair Hearing: At least 10 calendar days before the fair hearing, the Board of Hearings will send you a notice telling you the date, time, and place of the hearing. This will give you time to get ready for the hearing. If you want to have a fair hearing scheduled as soon as possible, check Box B in Section III on the fair hearing request form for an expedited hearing. If you

have good cause for not being able to come to the hearing, or if you need a telephone hearing, you must call the Board of Hearings at 617-210-5800 or 1-800-655-0338 before the hearing date. If you do not reschedule or appear on time at the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing: At the hearing, you may represent yourself or be represented by a lawyer or other representative at your own expense. You may contact a local legal service or community agency to get advice or representation at no cost. To get information about legal service or community agencies, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

If You Need an Interpreter or an Assistive Device: If you do not understand English and/or are hearing or sight impaired, the Board of Hearings will provide an interpreter and/or assistive device for you at the hearing. Please check either Box C or D, or both, in Section III on the fair hearing request form if you need an interpreter or assistive device, or call the Board of Hearings at 617-210-5800 or 1-800-655-0338 at least five business days before the hearing.

Your Right to Review Your Case File: You and/or your representative can review your MassHealth case file before the hearing. To do this, call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss) before the fair hearing. Your MassHealth case file is not kept at the Board of Hearings.

Your Right to Ask to Subpoena Witnesses, and Your Right to Question: You or your representative may write to the Board of Hearings to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and cross-examine witnesses at the hearing. The hearing officer will make a decision based on all evidence presented at the fair hearing.

NONDISCRIMINATION NOTICE FOR APPLICANTS AND MEMBERS: Under federal and state law, MassHealth does not discriminate on the basis of race, color, sex, sexual orientation, national origin, religion, creed, age, health status, or handicap.

Name: [REDACTED] SSN: [REDACTED] Date: 08/11/2009

*** Keep this copy. ***

FAIR HEARING REQUEST FORM

Fill out all sections that apply. Print clearly.

SECTION I: Applicant/Member Information

Name of Applicant or Member: _____
Address: _____
Telephone No.: () _____
MassHealth I.D. or Social Security Number: _____
Cardholder's Name on MassHealth card (if different): _____

SECTION 11: Reason for Appeal

I, _____ want a fair hearing because:

Signature: _____ Date: / /

SECTION 111: Appeal Information

(Check the boxes that apply to you.)

- () A. I do not want to keep getting MassHealth during the appeal process
() B. I want an expedited hearing.
() C. I need an interpreter (what language?: _____) to be provided by the Board of Hearings.
() D. I need an assistive device to be provided by the Board of Hearings. (Describe what type of assistive device you need. For example: American Sign Language): _____

SECTION IV: Appeal Representative, if any

My appeal representative is: _____
Title: _____

Address : _____
 Telephone No. : () _____

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Name: [REDACTED] SSN: [REDACTED] Date: 08/11/2009

*** Mail or Fax this copy. ***

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Address:
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Close