Commonwealth of Massachusetts
PO Box 4405
Taunton, MA 02780-0419

You can get this information in large print and braille. Call **(800) 841-2900** from Monday through Friday, 8:00 A.M. to 5:00 P.M. **TDD/TTY: 711.**

000000

[redacted]

Date: July 21, 2023
Notice ID: 0034103012 / TERMINATION
Member ID: [redacted]
SSN: XXX-XX[redacted]

Dear [redacted]

We have determined that the person listed below does not qualify for MassHealth, Health Safety Net, or the Children's Medical Security Plan.

Why doesn't the person on this letter qualify for MassHealth, Health Safety Net, and the Children's Medical Security Plan?

The person listed below does not qualify because:

- **Name:** [redacted] **Member ID:** [redacted] **Date of Birth:** XX-XX-[redacted]
  - The person cannot be found. 130 CMR 503.002 (G)(2)

This coverage is ending on August 04, 2023

If you think the person listed in this letter may qualify for benefits based on pregnancy, disability, a decrease in income or a change in immigration status, call MassHealth Customer Service at (800) 841-2900. TDD/TTY: 711.

What else do you need to know?
The **Member Booklet** explains income rules, premiums, copays and covered services for MassHealth. To get a copy, go to www.mass.gov/masshealth-member-library or call the MassHealth Customer Service Center at (800) 841-2900. TDD/TTY: 711.

How can you report changes?
You can report any changes in your information to MassHealth at any time. This includes any change to your income, address, phone number, family size, job, or health insurance.

You can give us information in the following ways.

1. **Online (*Recommended*):** The fastest way to update your information for your household is online through our website at MAhealthconnector.org.
   - Go to https://www.mahix.org/individual/code/9WVPFI where you will be able to create an account and see your information.
2. **Fax: 1-857-323-8300**
3. **Mail:** Commonwealth of Massachusetts
   Health Insurance Processing Center
   PO Box 4405
   Taunton, MA 02780-0419
4. **Call: (800) 841-2900. TDD/TTY: 711.**

What if you do not agree with our decision?
You can ask for a fair hearing if you do not agree with our decision.

- Read ***How to Ask for a Fair Hearing*** that came with this letter.

What if you have questions?
If you have questions or need more information, go to MAhealthconnector.org or call MassHealth Customer Service at (800) 841-2900. TDD/TTY: 711.

Thank you.

MassHealth

How to Ask for a Fair Hearing

Your Right to Appeal. If you disagree with the action taken by MassHealth, you have the right to appeal and ask for a hearing before an impartial hearing officer. You can also request a hearing if MassHealth did not act on your request in a reasonable time.

How to Appeal. To ask for a hearing, fill out this hearing request form and send it to the **Appeal Processing Center, PO Box 4405, Taunton, MA 02780-0419 or fax it to 1-857-323-8300.** If you have a question about your hearing call 617-847-1200 or 1-800-655-0338.

The Board of Hearings must receive your completed, signed request within 60 calendar days from the date you received the notice of our action. If you did not receive a written notice of the action to be taken, or MassHealth did not take an action on your application, you must send your request no later than 120 calendar days from the date the action takes place.

If You Are Now Getting MassHealth Benefits. You may be eligible to keep your benefits between the time you appeal and the time that the Board of Hearings makes a decision to approve or deny your appeal. If you decide to keep your benefits between the time the appeal is pending, and then you lose your appeal, you may have to pay back the cost of the benefits you received. If you do not get benefits, and then you win your appeal, we will restore your benefits. You will keep your benefits if the hearing form is received either before the benefit stops or within 10 calendar days from the mailing date of the MassHealth notice, whichever is later. Please mark your choice in the "If You Are Now Getting Benefits" section of the form.

Date of Hearing. At least 10 days before the hearing, we will send you a notice telling you the date, time and place of the hearing. Your hearing may be conducted by phone. You can ask us to reschedule a hearing, but you must have good cause. If you do not reschedule or appear on time to the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing. At the hearing, you may have a lawyer or other person represent you, or you may represent yourself. We will not pay for anyone to represent you. You may contact a local legal aid service or community agency to see if you can receive advice or representation at no cost. A hearing request can also be filed on your behalf by an individual authorized to act on your behalf. If someone other than a lawyer is acting on your behalf, please attach a copy of the document authorizing that person to file a hearing request on your behalf (for example, Power of Attorney, Guardian, Health Care Proxy).

If You Need an Interpreter, Assistive Device, or Other Accommodation. If you do not understand English or if you are hearing or sight impaired, we will provide an interpreter or assistive device at the hearing at no cost to you. We will also make other reasonable accommodations a person with a disability may need to participate in the hearing. Please tell us what you need in the "Other Information" section of the form.

Your Right to Review Your Case File. You and/or your representative can review your case file before the hearing. If you wish to review your case file, call (800) 841-2900. TDD/TTY: 711.

Your Right to Ask to Subpoena Witnesses and Your Right to Question. You or your representative may write 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. This means you can ask questions of witnesses. The hearing officer will make a decision based on all evidence presented at the hearing.

Impact on Other Household Members. Please note that an appeal decision for one household member may result in a change in eligibility for other household members. If that happens, any affected household members will receive a new eligibility notice explaining the changes.

[redacted] Member ID: [redacted]

Fair Hearing Request Form

First Name | Middle Initial | Last Name

Mailing address | City | State | Zip

Phone Number | Member ID | Date of Birth

Reason For Your Appeal (Circle any reason(s) that may apply.)

Income | Citizenship/Immigration Status | Access to Other Insurance

Family Size | Residency | Incarceration Status

Other: _____

Please explain why you are appealing. Attach any documents that support your reason.

Other Information (Check one if you are now getting MassHealth.)

__ I accept the proposed change in my coverage during the appeal process. If you check this line and you win your appeal, we will restore your original level of benefits.

__ I want to keep the benefits during the appeal process that I was receiving before. If you check this line, and you lose your appeal, you may have to pay back the cost of the benefits you received during your appeal.

__ I need an interpreter. My language is _____ (We will provide the interpreter for the hearing.)

__ I need an assistive device to communicate at a hearing. _____ (Describe what type of device you need, and we will provide an assistive device for the hearing.)

__ I need another accommodation for a disability. (Describe the accommodation needed.)

__ I need an expedited hearing

Name of Appeal Representative, if you have one:

Appeal Representative name | Phone number

Mailing address | City | State | Zip

Signature

The information on this form is true and accurate, to the best of my knowledge. I authorize MassHealth to provide me and my representative, if I have one, with my individual information, including federal and state tax information used in the determination of my eligibility, for purposes of this appeal process.

Signature (Sign) | Date | First and Last Name (Print)

If this is signed by someone other than an appellant 18 years of age or older who has authority to file, please attach a copy of your authority to file the appeal on behalf of the appellant (for example, a copy of your power of attorney document or evidence of court appointment as a personal representative).

This information is important. It should be translated right away.
We can translate it for you free of charge.
Call us at (800) 841-2900. TDD/TTY: 711.

Esta información es importante y debe ser traducida inmediatamente. Podemos traducirla para usted gratuitamente. Llámenos al (800) 841-2900 o por TDD/TTY: 711. (Spanish)

Esta informação é importante. Deverá ser traduzida imediatamente. Nós podemos traduzí-la para você gratuitamente. Entre em contato conosco no (800) 841-2900. TDD/TTY: 711. (Brazilian Portuguese)

此處的資訊十分重要，應立即翻譯。我們可以免費爲您翻譯。請撥打電話號碼 (800) 841-2900 (TDD/TTY: 711)，與我們聯繫。 (Chinese)

Enfòmasyon sa enpòtan. Yo fèt pou tradwi li tou swit. Nou kapab tradwi li pou ou gratis. Rele nou nan (800) 841-2900. TDD/TTY: 711. (Haitian Creole)

Những tin tức này thật quan trọng. Tin tức này cần phải thông dịch liền. Chúng tôi có thể thông dịch cho quý vị miễn phí. Xin gọi cho chúng tôi tại số (800) 841-2900. TDD/TTY: 711. (Vietnamese)

Эта информация очень важна. Ее нужно перевести немедленно. Мы можем перевести ее для вас бесплатно. Позвоните нам по телефону (800) 841-2900. TDD/TTY: 711. (Russian)

هذه المعلومات هامة. يجب ترجمتها فوراً. يمكننا ترجمتها لك مجاناً. اتصل بنا على الرقم 841-2900 (800). TDD/TTY: 711. (Arabic)

នេះគឺជាព័ត៌មានសំខាន់ៗ វាគួរតែបានបកប្រែភ្លាមៗ។ យើងអាចបកប្រែវាសំរាប់អ្នកដោយឥតគិតថ្លៃឡើយ។ សូមទូរស័ព្ទមកយើង តាមលេខ (800) 841-2900។ TDD/TTY: 711។ (Khmer)

Cette information est importante. Prière de la traduire immédiatement. Nous pouvons vous la traduire gratuitement. Appelez-nous au (800) 841-2900. TDD/TTY: 711. (French)

Questa informazione e importante. Si pregha di tradurla inmediatamente. Possiamo tradurla per voi gratuitamente. Chiammate all (800) 841-2900. TDD/TTY: 711. (Italian)

이 정보는 중요합니다. 이는 즉시 번역해야 합니다. 저희는 귀하를 위해 이를 무료로 번역해드릴 수 있습니다. 일반 전화인 경우 (800) 841-2900로, TDD/TTY 전화인 경우 711로 연락해 주십시오. (Korean)

Αυτή η πληροφορία είναι σημαντική και πρέπει να μεταφραστεί άμεσα. Μπορούμε να τη μεταφράσουμε για εσάς δωρεάν. Καλέστε μας στον αριθμό (800) 841-2900. TDD/TTY: 711. (Greek)

To jest ważna informacja. Powinna zostać niezwłocznie przetłumaczona. My tłumaczymy dla Państwa bezpłatnie. Prosimy do nas zadzwonić pod nr (800) 841-2900. TDD/TTY: 711. (Polish)

यह जानकारी महत्वपूर्ण है। इसका अनुवाद भलीभांति किया जाना चाहिए। हम आपके लिए इसका अनुवाद निशुल्क कर सकते हैं। हमें (800) 841-2900। TDD/TTY: 711 पर कॉल करें। (Hindi)

આ માહિતી મહત્વની છે. તેનું તરત જ અનુવાદ થવું જોઇએ. અમે વિના મૂલ્યે તમારા માટે તેમ કરી શકીએ છીએ. અમને (800) 841-2900. TDD/TTY: 711 પર કૉલ કરો. (Gujarati)

ຂໍ້ມູນນີ້ສຳຄັນ. ມັນມີຄວນຈຳເປັນຕ້ອງແປເລີຍ. ພວກເຮົາ ສາມາດຊ່ວຍແປໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາພວກເຮົາໄດ້ທີ່ (800) 841-2900. TDD/TTY: 711. (Lao)

This information is available in alternative formats such as braille and large print.
To get a copy, please call us at (800) 841-2900. TDD/TTY: 711.

MassHealth

MassHealth complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation or sex (including gender identity and gender stereotyping). MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation or sex (including gender identity and gender stereotyping).

MassHealth provides

→ free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, braille, accessible electronic formats, and other formats)

→ free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact us at (800) 841-2900. TDD/TTY: 711.

If you believe that MassHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping), you can file a grievance with: Section 1557 Compliance Coordinator, 1 Ashburton Place, 11th Floor, Boston, Massachusetts 02108, Phone: (617) 573-1704, TTY: (617) 573-1696, Fax: (617) 889-7862, or email at: Section1557Coordinator@state.ma.us. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Compliance Coordinator can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or by phone at (800) 368-1019, (800) 537-7697 (TDD).

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.