MA21 Notice

EDMC
P.O. BOX 4405
TAUNTON MA 02780-0968

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

Tel: (800) 322-1448
TTY: (888) 665-9997
Fax: (857) 323-8300

Medicaid ID : 100008308031

550/T *003239*
GREATER BOSTON LEGAL SERVICES
c/o NANCY LORENZ
197 FRIEND ST
BOSTON MA 02114

Attn: GREATER BOSTON LEGAL SERVICES Re: Notice sent to [redacted]

Date: 12/19/2018 Notice: 59953395 SSN: XXX-XX[redacted]

Dear [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.

MassHealth

MassHealth is ending coverage for the following MassHealth members because of the reasons listed below. We will stop paying for medical services for these members on the date listed below. This notice applies **only** to the family members listed below.

continued...

Name	SSN/DOB	Coverage End Date	Medicaid ID
[redacted]	XXX-XX-[redacted]	03/19/2019	[redacted]

Reason and Manual Citation

Your family's income is too high for you to get MassHealth Standard or your immigration status does not meet the rules for MassHealth Standard. You have a deductible of $5,306 to meet to become eligible for MassHealth CommonHealth. The deductible period is 12/09/2018 to 06/10/2019. 130 CMR 505.002 506.009 504.002

This notice is only about determining your eligibility as a disabled person. If you are already receiving health benefits from MassHealth or the Health Connector, you will still get these benefits.

If you have a deductible, you may be able to get MassHealth CommonHealth coverage if you send us bills for medical services you got before or during the deductible period. The bills may be for you or your family members and must add up to or be more than the deductible amount listed above. The Member Booklet describes how we decide your deductible and how you can meet it.

Please be aware that individuals with disabilities who work 40 hours per month or more or who are working and have been employed at least 240 hours in the previous 6 months may be eligible for MassHealth CommonHealth coverage without having a deductible. If you begin working more than 40 hours per month or are working and have worked at least 240 hours in the previous 6 months, call the number at the top of this notice right away to get information about how to start your coverage.

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 Member 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.

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 II-Reason for Appeal**) and send a copy with a copy of the MassHealth official written notice to: **Appeal Processing Center, P.O. Box 4405, Taunton, MA 02780-0419** or fax them to **1-857-323-8300**. Please keep a 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 **617-847-1200** 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 who are deaf, hard of hearing, or speech disabled).

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 **617-847-1200** 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 who are

deaf, hard of hearing, or speech disabled) 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: XXX-XX-[redacted] Medicaid ID: [redacted]
Notice: 59953395 Notice Date: 12/19/2018

*** Mail or Fax this form ***

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 II: Reason for Appeal

I, ____________________ want a fair hearing because:
____
____
____

Signature: ____________________ Date: __/__/__

SECTION III: 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.: ( ) ____________