State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
QUAKERBRIDGE PLAZA—BUILDING 7 & 5
QUAKERBRIDGE ROAD
TRENTON, NEW JERSEY 08619

ADDRESS REPLY TO:
CN-712
TRENTON, NEW JERSEY 08625

MEDICAID COMMUNICATION NO: 87-12 DATE: April 13, 1987

TO: County Welfare Agency Directors

SUBJECT: Medicaid Only Notification Form

Attached for your review is a prototype of the Medicaid Only Notification Form to be used by the County Welfare Agencies in notifying applicants and clients of eligibility decisions relating to the Medicaid Only program.

This form replaces the form PA-15 currently used for client notification. Revision of this form is necessary because of the assumption of administrative responsibilities for the Medicaid Only program by the Division of Medical Assistance and Health Services. Most notably, this notification form will advise the applicant/recipient to request a fair hearing through the Division of Medical Assistance and Health Services rather than the Division of Public Welfare.

With regard to production and issuance, the form must be county specific. Therefore, it must be reproduced on county letterhead in order to include necessary information such as agency address and telephone number.

If you should have any questions, you may contact Kathryn Plant, Office of Eligibility Policy at (609) 588-2936.

Sincerely,

Thomas M. Russo, Director
Division of Medical Assistance
and Health Services

TMR/CP/r
Enclosure
c: Odella T. Welch
Deputy Commissioner

Marion E. Reitz, Acting Director
Division of Public Welfare

Thomas Blatner, Director
Division of Youth and Family Services Management Team

To: _____ Case No. _____

_____ Date: _____

_____

This notification is to advise you of the following decision concerning your eligibility for the Medicaid program.

☐ Eligible Effective _____ ☐ Terminated Effective _____

☐ Denied

This action has been taken because:

_____

_____

_____

This action is required by the following regulations:

_____

_____

Request for a Fair Hearing

You have the right to request a fair hearing on this action. You must request a fair hearing within 20 days of the date of this letter. If you have been receiving Medicaid benefits and request a fair hearing within the 20-day period, your Medicaid benefits will continue until a hearing decision is reached so long as you remain eligible in all other respects.

HOW TO REQUEST A FAIR HEARING

To request a hearing, complete the reverse side, detach and send to:

Chief, Bureau of Research and Development

CN 712

Trenton, New Jersey 08625

Your Rights

Concerning the fair hearing, you have the right to:

*Present your own case or have a friend, relative or attorney make the presentation.

*Submit any evidence and/or bring any witnesses that bear on your case.

*Examine records or case files (including the application form). You may also examine the case record in advance, except for confidential records which are protected from release and which may not be introduced by the county welfare agency as evidence.

*Review a complete and up-to-date copy of the Medicaid Only Manual.

Important: If the decision of the State hearing is not in your favor, you may be required to repay any Medicaid benefits to which you were not entitled.

Legal Services

If you wish free legal counsel, you may consult with_____

_____

Legal services are private, nonprofit organizations that are not connected in any way with the county welfare agency or any other government agencies, and they provide free legal services, in most matters, to poor people.

If you have been denied or terminated, you have the right to reapply for the Medicaid program if there is a change in your current circumstances.

Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the grounds of race, color, national origin, age, or handicap in the administration of any program for which federal funds are received.

_____ _____

Eligibility Worker's Name Telephone Number

_____ _____

Eligibility Worker's Signature Date

REQUEST FOR FAIR HEARING

( ) I want a fair hearing because_____

_____

_____ _____

Signature Name

_____ _____

Date Address

_____

_____

Telephone Number