



State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO Box 712
TRENTON, NEW JERSEY 08625-0712

RONALD T. DiFRANCESCO
Acting Governor

JAMES W. SMITH, JR.
Acting Commissioner

DEBORAH C. BRADLEY
Acting Director
1-800-356-1561

MEDICAID COMMUNICATION NO: 01-26

DATE:
December 7, 2001

TO: County Welfare Agency Directors

SUBJECT: Revised Fair Hearing Request

To ensure that clients understand and access due process related to denials, additional revisions have been made to the Fair Hearing Request form issued in Medicaid Communication 01-17. We have included a grammatically correct sentence in Spanish advising Spanish-speaking clients to contact your office if they have questions regarding the process. Please fill in a phone number where their questions can be answered. Also, the request form now contains a statement referring low-income clients to the Legal Services of New Jersey: Health Care Access Program. Additionally, the form now includes information regarding how to obtain a Certificate of Creditable Coverage that had previously been omitted.

Once a client's request for a fair hearing has been received by the Fair Hearing Unit, a copy of that completed request will be forwarded to your agency. This will alert you to the request for a fair hearing and the election to continue benefits so that necessary action may be taken to update the eligibility file.

After a fair hearing has been completed and a final decision has been made, a copy of the Final Agency Decision (FAD) will be forwarded to the appropriate county welfare agency. This will serve as the Director's instruction to implement that decision.

A prototype of the revised fair hearing request is attached to this communication. The format is such that it can be easily duplicated on your agency's letterhead.

Questions concerning this communication should be referred to the field staff assigned to your county.

Sincerely,

Deborah C. Bradley
Acting Director

DCB:Sa

Attachment

C: George DiFerdinando, Acting Commissioner
William Conroy, Deputy Commissioner
Department of Health and Senior Services

David C. Heins, Director
Division of Family Development

Charles Venti, Director
Division of Youth and Family Services

Importante: Si usted no entiende esta noticia, póngase en contacto con un representante de esta oficina _____.

To: _____ Re: _____
_____ Program: _____
_____ Case # _____
_____ 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: _____

FAIR HEARING NOTICE

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 may continue until a hearing decision is reached so long as you remain eligible in all respects. **However, if the fair hearing decision is not in your favor, you may be required to repay any Medicaid benefits to which you were not entitled.**

If you expect to purchase or receive health insurance through an employer within the next two months, in order to avoid being denied payment for services for preexisting health conditions, you may need to provide your health insurer with a Certificate of Creditable Coverage, which will provide proof of continuous medical coverage. **To request this Certificate of Creditable Coverage, call (609) 588-3721.**

FAIR HEARING REQUEST

To request a fair hearing, complete this section in full and send a legible copy of this form to:

Division of Medical Assistance and Health Services
Fair Hearing Unit
P.O. Box 712
Trenton, New Jersey 08625

If you require assistance, please call (609) 588-2655.

I want a fair hearing because:

Only if your Medicaid benefits were terminated, check one:

___ I wish to continue my Medicaid benefits.
___ I do not wish to continue my Medicaid benefits.

If other than the applicant/recipient completed this request please complete:

Name of representative _____ Telephone # _____
Address _____

YOUR RIGHTS

Concerning the fair hearing, you have right to:

- Present your own case or have a relative, friend 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 those 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.

If Regarding Legal Services

You have the right to legal counsel at your fair hearing. For individuals who cannot afford to pay for the services of an attorney, there are private legal services organizations available which provide free legal counsel.

If you wish free legal counsel, you may consult with: Legal Services of New Jersey: Health Care Access Project, (toll free) 1-888-576-5529 or (local legal services).

If you have been denied eligibility or have had your eligibility terminated, you have the right to reapply for Medicaid benefits if there is any 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