TEXAS Health and Human Services Commission

Individual Name		
Individual No.	Date	
HHSC Staff	Region	Unit No.
Office Address and Telephone No.		

(Individual Name and Address)

☐ **Notice of Change in Applied Income or Co-Pay**

As a result of a review of your current situation, it is determined that the amount you pay the nursing facility/provider each month will be

☐ **Raised** ☐ **Lowered** From $ _____ to $ _____ beginning _____

This is Based On:

☐ A change in your regular monthly income.

☐ A projected amount, which considers the following:

☐ An average of your income, because your income from _____ varies from month to month.

☐ A deduction from your income for certain allowable ☐ medical expenses, ☐ home maintenance

☐ Federal regulations; your case is scheduled for review in _____ At that time, the projected amount will be adjusted according to your actual income and medical expenses for the months of _____ through _____

☐ The deletion of: ☐ variable income, ☐ incurred medical expenses, ☐ home maintenance deduction.

☐ **Notice of Denial of Medical Assistance**

As a result of the review of your current situation and the policy found in Section _____ of the Medicaid for the Elderly and People with Disabilities Handbook, we have determined that after _____ you WILL NOT be eligible for:

☐ Regular Medicaid Benefits

☐ Community Based Alternatives Benefits or other waiver services

☐ Community Attendant Primary Home Care Services

☐ Payments to State Supported Living Center

Medicare Savings Programs/

☐ Qualified Medicare Beneficiary (QMB) Benefits

☐ Qualified Disabled and Working Individuals (QDWI) Benefits

☐ Qualifying Individuals (QI-1) Benefits

☐ Specified Low-Income Medicare Beneficiary (SLMB) Benefits

Reason for Ineligibility:

Provider	Vendor No.	Effective Date:

Comments: (up to 3 lines - if more room is needed, use a separate sheet.)

If you have questions, please contact this office. Your right to apply for the medicare prescription drug and your right to a hearing is explained on page 2.

Request to Appeal Eligibility Determination Decision

You may request a hearing to appeal this decision before it is final. Your right to appeal this decision is lost 90 days from the date of this letter. If you request a hearing within 13 days from the date of this letter, you may be able to continue receiving assistance in the old amount until the hearing is completed. If the results of the appeal agree with the action taken in your case, then you may be asked to pay back the benefits provided to you during the appeal period.

If you request a hearing, you may be represented by an authorized representative, a relative, a friend or legal counsel. Free legal help from outside the department is available in many communities; call your local department office for information. If either you, your representative or a hearing officer asks, I will be present at the hearing.

Whether or not you want a hearing, you may request an informal conference to discuss this decision. If you want a conference, contact me and I will make the arrangements.

If you do not want a hearing, do not return this letter. If you do not return your request for a hearing within 90 days from the date of this letter, you will lose your right to a hearing.

DENIED MEDICAID RECIPIENTS: The administrator of Medicaid claims processing will send you a Certificate of Coverage. You can use this Certificate to prove how long you had a Medicaid coverage if you enroll in another medical plan that has a pre-existing condition clause. If you do not receive the Certificate within two weeks after you receive this notice, or if you lose the Certificate and need a replacement within the next 24 months, you may request a Certificate by calling 1_800_723_4789.

DENIED MEDICARE COST SHARING RECIPIENTS: Prescription drug coverage is available through Medicare effective January 1, 2006. The drug coverage helps with paying for prescriptions, but there are costs for premiums, deductibles and copayments. Even though you are not eligible for the Medicare Savings Programs, you may be eligible to receive help to reduce the cost of this new Medicare drug coverage. To find out if you are eligible for reducing your expenses for the drug coverage, you may apply through the Social Security Administration. You can apply online at www.socialsecurity.gov or you can call State Central Benefits Services at 1-800-248-1078 or Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Complete this section ONLY if you are NOT satisfied with this decision and wish to appeal:

☐ **Request for Appeal**

I file this as my appeal and want a hearing before a department hearing officer.

Signature – Individual

Date

Individual Name	Area Code and Telephone No.

Send this request for an appeal to the following address:

HHSC Staff	Mail Code
Office Address and Telephone No.	

Discrimination Complaints

If you believe you have been discriminated against because of race, color, national origin, age, sex, disability or religion, you may file a complaint by contacting:

HHSC Civil Rights Office, 701 W. 51st St., Suite 104, Austin, TX 78751

Voice: 1-888-388-6332, TTY: 1-877-432-7232, Fax: 1-512-438-5885

You can also file a complaint by contacting:

U.S. Department of Health and Human Services:1-800-368-1019 (toll free)

Office for Civil Rights - Region VI **TTY: 1-214-767-8940**

1301 Young St., Room 1169 **Fax: 1-214-767-0432**
Dallas, TX 75202