

NOTICE OF ELIGIBILITY OR INELIGIBILITY

This is to inform you that we have reviewed your circumstances and have found that you live at the address below. The following decision(s) have been made on your case(s). ONLY THE BLOCKS CHECKED APPLY TO YOU. Please see the back of this letter for important information about reporting changes requesting a fair hearing if you are dissatisfied with any action taken on your case. If you want to request a fair hearing, contact your worker by \_\_\_\_\_.

Case No. \_\_\_\_\_

Date \_\_\_\_\_

[ \_\_\_\_\_ ]

[ \_\_\_\_\_ ]

[ ]1. Your [ ]STATE SUPPLEMENTATION PAYMENT [ ]MEDICAL ASSISTANCE [ ]QUALIFIED MEDICARE BENEFICIARIES (QMB) BENEFITS [ ]PAYMENT FOR LONG TERM CARE has been or will be [ ]Denied [ ]Discontinued effective \_\_\_\_\_ in accordance with Manual Section(s) \_\_\_\_\_ because \_\_\_\_\_

[ ]2. Your benefits are [ ]STATE SUPPLEMENTATION PAYMENT of \$ \_\_\_\_\_ effective \_\_\_\_\_. [ ]MEDICAL ASSISTANCE effective \_\_\_\_\_. [ ]QMB BENEFITS effective \_\_\_\_\_. You must pay \$ \_\_\_\_\_ per month toward your care in a Long Term Care facility, Home and Community Based Services, Hospice or Alternate Intermediate Services/Mental Retardation Project effective \_\_\_\_\_. The following persons are included in your case \_\_\_\_\_

[ ]3. Your benefits shown in number 2 decreased according to Manual Section(s) \_\_\_\_\_ because \_\_\_\_\_

[ ]4. Your benefits shown in number 2 increased because \_\_\_\_\_

[ ]5. We are considering the following income in your case. \$ \_\_\_\_\_ Gross Earned and \$ \_\_\_\_\_ Gross Unearned.

[ ]6. We are considering the following deductions in your case. \$ \_\_\_\_\_ Work Expenses, \$ \_\_\_\_\_ Dependent Care, \$ \_\_\_\_\_ Medical Expenses, \$ \_\_\_\_\_ Conserved for Dependents, \$ \_\_\_\_\_ Community Spouse Income Allowance, \$ \_\_\_\_\_ Family Income Allowance, \$ \_\_\_\_\_ SMI, and \$ \_\_\_\_\_ Personal Needs Allowance.

[ ]7. Other \_\_\_\_\_

IF YOU OR ANY MEMBER OF YOUR CASE IS PREGNANT, THE PREGNANT INDIVIDUAL MAY BE ELIGIBLE TO CONTINUE TO RECEIVE MEDICAL ASSISTANCE.

ABOVE ACTION IS BEING TAKEN IN ACCORDANCE WITH THE STATE REGULATIONS AT 907 KAR 1:004 OR 1:011 OR KAR 904 2:015, 2:040 OR 2:046.

IF ANY OF THE AMOUNTS LISTED ABOVE ARE WRONG OR CHANGE, REPORT IT TO YOUR WORKER WITHIN 10 DAYS. PLEASE SEE THE BACK OF THIS LETTER FOR IMPORTANT INFORMATION AND TO REPORT CHANGES OR REQUEST A HEARING.

IF YOU WANT LEGAL HELP OR ADVICE, CONTACT YOUR ATTORNEY OR LOCAL LEGAL AID OFFICE AT \_\_\_\_\_

Worker \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

You can fill out this portion of the form to report a change to your worker or to request a hearing if you are dissatisfied with the decision on your case. An addressed envelope is included if you wish to mail this letter.

[ ] I wish to report the following changes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[ ] This change is for the month(s) of: \_\_\_\_\_

[ ] I wish to request a Fair Hearing because: \_\_\_\_\_  
\_\_\_\_\_

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_ Date Received \_\_\_\_\_

REPORTING CHANGES

Report the following changes within 10 days of the time you learn of them:

- |  |   |
|--|---|
| 1. Family income (amount and source)               | 7. Marital status                                 |
| 2. Household members                               | 8. School attendance of yourself or child over 16 |
| 3. Your address                                    | 9. Dependent care expenses                        |
| 4. Employment                                      | 10. Return of parent to the home                  |
| 5. Number of vehicles                              | 11. Discharge of someone in Long Term Care.       |
| 6. Sale of property or other increase in resources |   |

If for some reason you cannot mail this form, you may report the changes by calling your worker at the number on the front of this form. Failure to report changes within 10 days, or to give complete and true information, may make you subject to prosecution for fraud.

YOUR MEDICAL CARD

Any person whose name is shown on the medical card may receive needed medical services. However, never permit anyone not named on the card to use it. If you receive emergency medical care before you receive your Medical Assistance ID Card, present the card as soon as received to the provider of the medical services.

LET US HELP YOU KEEP YOUR FAMILY HEALTHY

You are invited to get a free health and dental check-up for your children and you, if you are under 21 years of age. The health check-up includes: eye and hearing test; a test for kidney problems, TB, low blood, growth and development; nutrition and general health will also be checked; and immunizations (shots) will be given if needed. If any problems are found during the check-up, you (if you are under 21) and your children will receive help in getting treatment for these problems. Contact your worker for assistance in making an appointment for the check-up and in arranging transportation.

HEARING PROCESS

You have the right to receive fair and impartial treatment from your worker regardless of your age, sex, race, religious beliefs, political affiliation, national origin, or handicap.

-If this form is providing notice of an action to be taken in your money payment or medical assistance case, you have the right to request a fair hearing in accordance with 904 KAR 2:055 within 40 days of the date of this notice. If you request a hearing within 10 days of the date on the reverse side of this notice, you may request that your assistance continue unchanged until a hearing decision is reached.

-If this form is providing notice of an action which has been taken on your money payment or medical assistance case, you have the right to request a fair hearing in accordance with 904 KAR 2:055 within 30 days. You may request a fair hearing by calling or writing your worker, or you may write to the Department for Social Insurance, Division of Administrative Review, 275 E. Main St., Frankfort, KY 40621.

-If you request a hearing on your benefits and the hearing is not ruled in your favor, your household may owe us the value of the extra benefits you received if you choose to continue receiving benefits at the same level pending the hearing.