MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Information Request

Date: 03/19/14

MassHealth Enrollment Center	
Address:	21 Spring Street, Suite 4
City/Town/Zip:	Taunton, MA 02780
MassHealth worker:	paula morin
Telephone:	(508) 828-4669
TTY:	1-888-665-9997 (for people with partial or total hearing loss)
Fax:	508-828-4634

[redacted]

Applicant/Member name	[redacted]
Applicant/Member social security number	[redacted]

☐ First request ☐ Second request

You must send copies of the information checked off on this form by **04/17/14** to the MassHealth Enrollment Center listed above. (Please put your name and social security number on the information you are sending to us and attach this request form.)

If you do not give us the information we are asking for, your MassHealth benefits may be denied or stopped. If you need help to get any information, call your MassHealth worker at the telephone number listed above.

Basic Information

- ☐ **Health Insurance:** a copy of your current health-insurance premium bills (like Medex)
- ☐ **Third-Party Liability** (enclosed): fill out and send back the Assignment of Third-Party-Recovery packet
- ☐ **MassHealth Disability Supplement** (enclosed): fill out, date, sign, and send back. Be sure to sign all medical release forms.
- ☐ **Spousal and Family Supplement (LTC-SFC)** (enclosed): fill out, date, sign, and send back. Be sure to give us proof of information, as explained in the LTC-SFS.

U.S. Citizenship/National Status, Immigration Status, and Identity Information

See pages 28-29 in the *MassHealth and You* guide for complete information about acceptable proofs.

- ☐ **Proof of BOTH U.S. Citizenship/National Status and Identity** (only acceptable documents to prove both): U.S. passport, Certificate of Naturalization (DHS Form N-550 or N-570), or Certificate of U.S. Citizenship (DHS Form N-560 or N561)

OR

- ☐ **Proof of U.S. Citizenship/National Status only** (some acceptable documents): U.S. public record of birth, Report of Birth Abroad of a U.S. Citizen (Form FS-545, Form FS-240, or Form DS-1350), U.S. Citizen ID card (INS Form I-197 or I-179), American Indian Card (I-872 with the classification code KIC) issued by the Department of Homeland Security (DHS) to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border, final adoption decree showing the child's name and U.S. place of birth, evidence of U.S. civil service employment before June 1, 1976, official military record showing a U.S. place of birth, Northern Mariana Identification Card (I-873) issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986
- ☐ **Proof of identity only** (some acceptable documents): state driver's license containing the individual's photo or other identifying information, government-issued identity card containing the individual's photo or other identifying information, Certificate of Indian Blood or other U.S. tribal document with photo or other identifying information
- ☐ **Proof of immigration status only** (some acceptable documents): Resident Alien Card (Form I-551), Employment Authorization Card (Form I-688A), Temporary Resident Card (Form I-688), Employment Authorization Document (Form I-688B), Employment Authorization Document (Form I-766), Reentry Permit (Form I-327), Refugee Travel Document (Form I-571), Arrival/Departure Record (Form I-94)

Long-Term-Care Information

(You must make sure the facility gives us this information.)

☑ **Residence:** notification of admission to facility (SC-1)

☑ **Private Payment for Long-Term-Care Services:** statement from facility showing amount paid to date and dates of coverage

☑ **Nursing Facility Screening Notification**

☑ **Personal Needs Account:** personal needs account statement from facility showing activity within the last 45 days

Assets Information

☐ **Tax Returns:** a copy of your federal tax returns for the last two years for both you and your spouse. If not available, send a filled-out and signed Form 4506 (enclosed with this form) to the Internal Revenue Service and send a copy to your MassHealth worker.

☑ **Bank Accounts** (including accounts set up for burial only) (Financial institutions cannot charge seniors for copies of bank or other financial records if MassHealth is asking for the information.)

[redacted]tatement for 1/5/14-2/5/14[redacted]erify where monies deposited at closing[redacted]

[redacted]nd of year statements for 2010 and 2011 and update from 12/31/12 to closing;

☐ **Life Insurance:** a copy of the first page of all life-insurance policies, including life insurance policies set up for burial only. If total face value of all policies exceeds $1,500, also send a letter from the insurance company showing the current cash-surrender value (for all policies except term policies)

☐ **Trusts:** all trust documents, any amendments, and accountings that show all assets in the trust including current balance and all activity during the period from _____ to _____. Also send proof of all income distributed during this period, a schedule of trust assets, and a schedule of beneficiaries. If a realty trust, send a copy of deed.

☑ **Burial Plans:** prepaid and dated irrevocable contract or irrevocable trust signed by both you and the funeral home director, or if unavailable an itemized statement from the funeral home director to prove the existence of an irrevocable burial contract or irrevocable trust, an irrevocable trust instrument, any burial insurance policy, or any statement signed by you designating a burial account or life insurance policy for burial expenses

☐ **Real Estate:** a copy of the deed(s), current tax bill(s), and proof of amount owed for all properties that you and/or your spouse have a legal interest in. Also send the following:

- ☐ Birth certificate proving relationship of child, sibling, or dependent relative
- ☐ Medical-, financial-, or other dependency-need signed statement attesting to the dependency of the dependent relative
- ☐ Statement of Expectation to Return Home (enclosed): filled out and signed by a doctor
- ☐ Medical statement for disabled/blind child (proof of disability)
- ☐ Signed medical statement that explains care provided to you by son or daughter for the past two years that allowed you to remain at home
- ☐ Document showing duration of relative's residence in home of institutionalized individual

☐ **Long-Term-Care Insurance:** all long-term-care insurance policies that are currently in effect

☐ **Vehicles/Mobile Homes:** titles or registrations to all vehicles and loan agreements; bill of sale for mobile homes

☐ **Stocks/Bonds/Other:** copies of certificates, current quote from stockholder, daily paper, or investment firm to prove current value, copies of savings bonds, and financial statements showing activity during the period from _____ to _____

☐ **Annuities:** contract showing owner's name, name of person getting income, company name, account number, dates of purchase, purchase price, amount of income received, rights (or absence of rights) to change beneficiaries, and list of beneficiaries

☐ **Transferred Resources:** all documents that transfer assets, income, and/or the right to income showing the date of transfer, value of asset or income on date of transfer, and name of person to whom transfer was made during the period from _____ to _____

☐ **Asset Assessment:** proof of all assets owned by you and/or your spouse:

- ☐ on the date of admission to the medical institution
- ☐ at the time of application
- ☐ from the period _____ to _____
- ☐ other: _____

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

TAUNTON OFFICE
21 SPRING ST, SUITE 4
TAUNTON MA 02780-3457

Tel: (800) 242-1340
TTY: (888) 665-9997
Fax: (508) 828-4634

Reference :

576/APPR *000420*

Attn: Re: Notice sent to

Date: 04/18/2014 Notice: SSN:

Dear

MassHealth Long-Term-Care Services in a Nursing Facility

MassHealth has decided that you are eligible for MassHealth Standard benefits to cover your care in a nursing facility. Your eligibility begins on 12/19/2013.

What Happens Next?
Starting in 12/19/2013, you will owe your nursing facility $847.23 every month to help pay for your care. Your nursing facility will bill you $847.23 every month. This is called your "Patient Paid Amount." At the end of this notice, you can see how we determined your Patient Paid Amount.

Reporting Changes
You must tell MassHealth about certain changes that could affect your coverage. These include any changes in income, family size, employment, student status, disability status, health insurance, address, and immigration status. This will let us determine the most complete coverage you can get. Address changes are needed so you will get notices about your benefits. Once a change occurs, please report the change to MassHealth within 10 days or as soon as possible.

continued...

For information about appealing our decisions, see the Request for a Fair Hearing page of this notice.

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 MassHealth booklet, please call to request one. It has important information about MassHealth coverage and rules.

How We Determined Your Monthly Patient Paid Amount (PPA):

Countable Income:		
Earned Income:		0.00
Social Security/Railroad Retirement:		1,197.00
Annuity:		0.00
Pension:		13.30
Veteran's Pension:		0.00
Other:		0.00
Total Countable Income:		1,210.30
Allowances:		
Personal Needs Allowance:	72.80	
Amount to Maintain Home:	0.00	
Spouse In Home:	0.00	
Family Members In Home:	0.00	
Medicare:	0.00	
Other Health Insurance:	290.27	
Guardianship Fees and Expenses:	0.00	
Other Medical Expenses:	0.00	
Total Allowances:	363.07	-363.07
Net Countable Income:		847.23
Amount You Pay Nursing Facility:		847.23

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 one copy with a copy of the MassHealth official written notice to: **Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171** or fax them to **617-847-1204**. Please keep one 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: [redacted] Reference [redacted]
Notice: [redacted] Notice Date: 04/18/2014

*** Keep this copy. ***

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.: ( )_____