FSSA Document Center
PO Box 1810
Marion, IN 46952

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## Eligibility Notice for Health Coverage

Indiana Family and Social Services Administration
PO Box 1810
Marion, IN 46952
Phone/Fax: 1-800-403-0864

Payee Name : [redacted]

Case Number : [redacted]

AG Number : 44271074

Program : Health Coverage

Mailing Date : JANUARY 19, 2023

[redacted]

### IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

It's time for your annual Medicaid/Hoosier Healthwise/Healthy Indiana Plan (HIP) eligibility review. We need to review your information and complete a redetermination of eligibility in order for your health coverage to continue. To continue your coverage for another year we need you to complete, sign and return this form.

**If you do not complete, sign and return this form your coverage will be discontinued effective MARCH 01, 2023.**

YOU MUST INCLUDE PROOF OF YOUR CURRENT INCOME AND RESOURCES WITH THE FORM.

We may request further proof of any changes and will notify you in writing if we need additional proof. Failing to provide requested documents or information could affect your eligibility for health coverage.

Sign the enclosed Medicaid/Hoosier Healthwise/HIP Eligibility Review Form and return it to us by the due date shown on the form. If you have any questions, please call the FSSA Call Center at 1-800-403-0864 between 8:00 a.m. and 4:30 p.m.

Return your completed form and any additional documents to:

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or Fax to the FSSA Document Center at 1-800-403-0864.

Or you may also take your completed form to the Office of Family Resources in your county. The locations of these offices are available at www.fssa.in.gov or by calling 1-800-403-0864.

**New!** You can now submit information for your redetermination online using the FSSA Benefits Portal at fssabenefits.in.gov. You will need to create an account, if you have not already done so. You can report any changes, upload documents, and electronically sign your redetermination form. **You will need to submit your income and assets from the last 30 days to complete your redetermination.** If we need more information from you after you submit information online, we will send you a separate request.

This form asks information about resources (assets). Resource (asset) information is only needed for determining eligibility for Medicaid for the Aged, Blind, Disabled, and Medicare Savings Programs.

**WHOSE ELIGIBILITY IS BEING REVIEWED?**

The Medicaid/Hoosier Healthwise/HIP Eligibility Review Form lists the people shown in this case. Each person is shown as either "eligible" or "ineligible" which is the member's status in this case. We are currently reviewing the circumstances of the family in this case. It may be possible that someone shown as ineligible is receiving health coverage in another case. If that is true, please just write in the space provided: "receiving Medicaid/Hoosier Healthwise/HIP" as appropriate in the space available under “correction”.

**SPECIAL CIRCUMSTANCES FOR MEMBERS IN LONG TERM CARE**

The Eligibility Review Form has questions about your income and assets. It explains for most situations whose information we need. However there are special rules for Medicaid members receiving long term care services. These rules apply to members who live in Medicaid facilities such as nursing homes, and those who are receiving Medicaid home and community-based waiver services.

You don't have to give income and asset information for:

1. Parents of children under age 18 who are on Medicaid in the disability or blind categories, who live in Medicaid facilities such as nursing homes, and those who are receiving Medicaid home and community-based waiver services if the parents themselves are not on Medicaid.
2. Community spouses who are not on Medicaid unless they want to receive some of their spouse's income. A community spouse for this purpose is one whose spouse is in a Medicaid facility or receiving waiver services under the Aged and Disabled Waiver.

You must tell us about any annuities that the member and spouse have. This includes annuity purchases and any non-routine transactions taken on an existing annuity. With these actions that occur on and after November 1 2009, the State must be named the remainder beneficiary on the annuity. (Section 1917(c) of the Social Security Act)

Thank you.

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## MEDICAID/HOOSIER HEALTHWISE/HIP ELIGIBILITY REVIEW

It is time for the annual review of your eligibility for Medicaid/Hoosier Healthwise/HIP. This is information we show currently in your case. If there are changes, please write them in the space provided and provide documentation of the new information.

PLEASE RETURN THIS FORM AND DOCUMENTS TO US NO LATER THAN FEBRUARY 20, 2023.

DON'T FORGET TO SIGN YOUR FORM ON THE LAST PAGE

| **HOME ADDRESS:** | | | | |
|---|---|---|---|---|
| ADDRESS LINE1 | ADDRESS LINE2 | CITY, STATE ZIP | PHONE | OTHER PHONE |
| [redacted] | | Indianapolis, IN 46204 | | |
| CHANGES/CORRECTIONS | | | | |

| **MAILING ADDRESS:** | | |
|---|---|---|
| ADDRESS LINE1 | ADDRESS LINE2 | CITY, STATE ZIP |
| [redacted] | | Indianapolis, IN 46204-2615 |
| CHANGES/CORRECTIONS | | |

We show the following persons living in your household. (This includes an eligible member who may be living in a health care or residential facility.) Please make any corrections in the third column such as a name change or correct spelling, a correction to birth date or comment "no longer living here". If an eligible Medicaid/Hoosier Healthwise/HIP member is no longer living at this address please give the current address if you know it.

| NAME | BIRTH DATE | CURRENT STATUS | CORRECTION |
|---|---|---|---|
| [redacted] | [redacted] | Eligible | |
| [redacted] | [redacted] | Eligible | |
| [redacted] | [redacted] | Eligible | |
| List Additional household members and their relationship to eligible members: | | | |

**EMPLOYMENT INFORMATION:**

Attach pay stubs for the last 30 days or provide a statement from your employer for each employed member.

| EMPLOYED MEMBER | EMPLOYER | GROSS EARNINGS | FREQUENCY |
|---|---|---|---|
| [redacted] | EMPW2 | $30.00 | Monthly |
| [redacted] | BBC | $20.00 | Monthly |
| [redacted] | EMP4 | $35.00 | Monthly |
| [redacted] | EMP5 | $45.00 | Monthly |
| [redacted] | EMPW1 | $15.00 | Monthly |
| [redacted] | EMPW4 | $19.00 | Monthly |
| [redacted] | EMP3 | $25.00 | Monthly |
| [redacted] | Walmart | $5.00 | Monthly |
| [redacted] | EMPW3 | $49.00 | Monthly |
| [redacted] | EMPW5 | $16.00 | Monthly |
| CHANGES/CORRECTIONS | | | |

**SELF EMPLOYMENT INFORMATION:**

Attach a copy of your most current income tax return including all schedules. If you do not file taxes, we need a copy of your self-employment records of income and expenses for the past twelve (12) months.

| SELF-EMPLOYED MEMBER | EMPLOYEE | TYPE | GROSS EARNINGS | FREQUENCY |
|---|---|---|---|---|
| [redacted] | QWQWQWQWWQ | QWQWQWQWWQ | $22.00 | Monthly |
| [redacted] | RRRRRRRR | RRRRRRRR | $31.00 | Monthly |
| [redacted] | SDSDSD | SDSDSD | $11.00 | Monthly |
| [redacted] | LLLLLLLLLLLKKKKK | LLLLLLLLLLLKKKKK | $44.00 | Monthly |
| [redacted] | MMMMMMMM | MMMMMMMM | $11.00 | Monthly |
| [redacted] | BBCV | BBCV | $35.00 | Monthly |
| [redacted] | PPPPP | PPPPP | $21.00 | Monthly |
| [redacted] | VBVBVBVBVB | VBVBVBVBVB | $31.00 | Monthly |
| [redacted] | OOOOO | OOOOO | $20.00 | Monthly |

| SELF-EMPLOYED MEMBER | EMPLOYEE | TYPE | GROSS EARNINGS | FREQUENCY |
|---|---|---|---|---|
| [redacted] | ERERERERERER | ERERERERERER | $31.00 | Monthly |
| CHANGES/CORRECTIONS | | | | |

**OTHER INCOME INFORMATION:**

Attach proof of the amount of each income type received for the most recent full month. If you wish, you may include in your attachment more than one month of income for each type. Supplemental Security Income (SSI) is not counted, child support, and veterans' benefits are not counted for Hoosier Healthwise and HIP.

| RECEIVED BY | TYPE OF INCOME | AMOUNT RECEIVED | FREQUENCY |
|---|---|---|---|
| [redacted] | Interest Income | $120.00 | Monthly |
| [redacted] | Retirement/Pension | $50.00 | Monthly |
| [redacted] | Interest Income | $120.00 | Monthly |
| [redacted] | Dividends | $10.00 | Monthly |
| [redacted] | Investment Income | $60.00 | Monthly |
| [redacted] | Other - Non-Exempt | $70.00 | Monthly |
| [redacted] | Investment Income | $130.00 | Monthly |
| [redacted] | Other - Non-Exempt | $140.00 | Monthly |
| [redacted] | Dividends | $100.00 | Monthly |
| [redacted] | Retirement/Pension | $110.00 | Monthly |
| CHANGES/CORRECTIONS | | | |

**RESOURCE INFORMATION:**

For any items below listed as "liquid assets," please provide all pages of your most recent monthly statement to verify the current balance. For all other items, note any changes, corrections, or new assets in the space provided and submit proof of the current value.

Resource (asset) information is only needed for determining eligibility for Medicaid for the Aged, Blind, Disabled, and Medicare Savings Programs.

| OWNER | RESOURCE TYPE | CASH VALUE | ADDITIONAL INFORMATION |
|---|---|---|---|
| [redacted] | Liquid Asset | $150.00 | Checking Account |
| [redacted] | Liquid Asset | $300.00 | Cash |
| [redacted] | Liquid Asset | $90.00 | Savings Account |
| [redacted] | Liquid Asset | $20.00 | Checking Account |

| OWNER | RESOURCE TYPE | CASH VALUE | ADDITIONAL INFORMATION |
|---|---|---|---|
| [redacted] | Liquid Asset | $100.00 | Savings Account |
| [redacted] | Vehicle | $250.00 | 2003 TYTY IIO |
| [redacted] | Vehicle | $200.00 | 2003 TOYOTA CAMRY |
| [redacted] | Liquid Asset | $190.00 | Savings Account |
| [redacted] | Liquid Asset | $210.00 | Stocks |
| [redacted] | Liquid Asset | $30.00 | Savings Account |
| [redacted] | Liquid Asset | $110.00 | Bonds |
| CHANGES/CORRECTIONS | | | |

**ELECTRONICALLY VERIFIED RESOURCE INFORMATION:**

Indiana is required to use an asset verification system to electronically verify assets (resources). This could affect your eligibility determination. Resources reported by an applicant or recipient are compared to what is returned from the AVS, and the higher countable value is used in determining eligibility.

If you have information you believe should reduce the countable amount of the resource, such as joint ownership, an amount still owed, or any other reason why the resource amount listed is not what should be considered under Medicaid rules, you must return an explanation and verification. For vehicles, if verification of value is not provided, we will default to the fair purchase price listed for a base model of the same make, model, and year.

| OWNER | RESOURCE TYPE | CASH VALUE | ADDITIONAL INFORMATION |
|---|---|---|---|
| CHANGES/CORRECTIONS | | | |

| **MILLER TRUST ACCOUNT:** | | |
|---|---|---|
| OWNER NAME | AMOUNT ADDED TO TRUST | FREQUENCY |
| CHANGES/CORRECTIONS | | |

ADDITIONAL INFORMATION: IF YOU HAVE ADDITIONAL INFORMATION TO REPORT, PLEASE ENTER THAT INFORMATION BELOW AND ATTACH DOCUMENTATION OF THE CHANGE.

Do you want to register to vote? (This will not affect your health coverage benefits.) ___Yes ___No

**YOUR SIGNATURE IS REQUIRED:**

I certify under penalty of perjury that the information provided on this form is correct and complete to the best of my knowledge and belief.

_____ _____

Signature Date signed (month, day, year)

Witness signature if above is signed with "X" _____

PLEASE MEET THE REQUESTED DEADLINE SO THAT WE CAN PROCESS YOUR ELIGIBILITY REVIEW WITHOUT DELAY.

You may receive a request from us if we need additional information or proof of any changes that you have indicated or that we discover. You will also receive a notice on whether your health coverage benefits will continue or end based on your eligibility redetermination.

THANK YOU VERY MUCH FOR YOUR COOPERATION.

**If this notice says that your Medicaid was denied or closed because the value of resources exceeds program eligibility standards…**

The decision referenced in this notice was based, in whole or in part, on information obtained from the consumer reporting agency listed below. The decision made was not based upon a numeric credit score. The consumer reporting agency did not make the decision referenced in this notice and is unable to provide you with the specific reasons why the decision was made.

Under the Fair Credit Reporting Act, you have the right to obtain a free copy of your consumer file from the consumer reporting agency, if you request it no later than 60 days after you receive this notice. In addition, if you find that any information contained in the file you receive is inaccurate or incomplete, you have the right to dispute the matter with the consumer reporting agency.

You may contact the consumer reporting agency at the toll-free number listed below or in writing at the listed address to obtain the applicable contact information for your consumer reporting agency handling your file. The consumer reporting agency will be providing you any additional information regarding your rights under Fair Credit Reporting Act.

Softheon Inc, Contact Number: 888-780-7764 PO Box 1628 Stony Brook, New York 11790

**If you disagree with our decision**

You have the right to appeal our determinations such as your monthly income, POWER account contribution amount, or category of benefits. This notice includes instructions for filing an appeal. Please read this information carefully.

**Timelines and process for appealing**

You must file your appeal in writing by close of business within thirty-three (33) days of the date of the notice or the effective date of the action you are appealing, whichever is later. Please note that close of business means 4:30 pm local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal by the next business day. If you mail your appeal, your appeal will be considered filed on the date of receipt and not on the postmarked date.

An FSSA representative will notify you of the next steps. If FSSA schedules a hearing we will notify you in writing of the date, time, and place for the hearing. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative.

**How will the appeal impact my benefits?**

If you submit your request for the appeal prior to the effective date of the change in your coverage listed in this notice, you will be able to receive the same level of benefits you are currently receiving while your appeal is pending. However, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contribution during your appeal in order to continue receiving HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you will lose access to HIP Plus or HIP State Plan Plus benefits and you may lose your HIP eligibility.

You should expect a short delay in having your current coverage continue if we receive your appeal request near the deadline, but we will restore the benefits retroactively so that you have no break in coverage.

If you submit your request for appeal after the effective date of the change in your coverage listed in this notice, you will receive your new benefits while your appeal is pending.

**Can I maintain my current benefits during the appeal?**

As indicated in this notice, you will maintain your current HIP benefits while your appeal is pending if you submit your request for appeal prior to the effective date of the discontinuation of benefits listed in this notice. However, if your benefits were discontinued because you did not make a timely POWER account contribution or premium payment, then you may not maintain benefits during your appeal. Also, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contribution during your appeal in order to continue receiving HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you will lose access to HIP Plus or HIP State Plan Plus benefits and you may lose your HIP eligibility.

**Back payments for HIP POWER account**

If you become ineligible for any HIP services and the administrative law judge at the hearing for your appeal rules in your favor, your coverage will be restored back to the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account contributions that accrued during your appeal. You will lose HIP eligibility if you do not repay this amount timely.

**How to file an appeal**

You can mail, fax, or hand deliver your written appeal request.

To appeal, please send a signed letter with as much information as possible including your Name, Case Number, and Reason for the appeal, along with a copy of this entire notice to one of the following locations listed below. For your case, this information is provided below for your convenience.

Name: [redacted]

Case Number: [redacted]

Date of Notice: JANUARY 19, 2023

County: 49

1. Mail your written appeal to:

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or,

2. Fax your written appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

**FOR MORE INFORMATION ABOUT THE FAIR HEARING PROCESS**

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

Local Office of Family Resources

MARION COUNTY DFR
3266 N Meridian St
Ste 1024
Indianapolis, IN 46208
PHONE: 1-800-403-0864