FSSA Document Center
PO Box 1810
Marion, IN 46952

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COVID-19 Mailer Notice

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 : 18781209
Program : Health Coverage
Mailing Date : MARCH 01, 2023

[redacted]

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE AFTER COVID-19 FEDERAL PUBLIC HEALTH EMERGENCY RULES END

Your health coverage has continued at the same level through Medicaid or the Healthy Indiana Plan due to the COVID-19 federal public health emergency. **Based on the information FSSA has on file, we are not able to tell if you are still eligible for your current health coverage.**

Your coverage is set to change because federal legislation removed Medicaid coverage protections from the federal public health emergency rules on MARCH 31, 2023.

The reason your health coverage is set to change is:

- PREGNANCY HAS TERMINATED AND 12 MONTH EXTENSION HAS EXPIRED
- ASSISTANCE GROUP MEMBER(S) LEFT THE HOME

We need to review your information to determine if you are eligible for your health coverage to continue after the COVID-19 federal public health emergency rules end. **You may still be eligible for your current coverage when you provide more information.**

1. This form lists the information that FSSA already knows about you, including what you have told us in the past. If FSSA does not have all of the people, income, resources (assets) or other items for your household listed or it is not correct, make notes and corrections on the redetermination form.

2. For all income sources for your family, provide the latest thirty (30) days of proof of income. This could be paystubs or an employer's signed statement of your gross income (before taxes or deductions). FSSA will re-evaluate your eligibility based on the most current information you provide.

3. If an income source listed has stopped but you do not have a way to prove it, you can write a statement telling FSSA the details. Be sure to include as much information as possible, including the income source name, amounts, and dates for the last month you received it. Sign and date this statement before turning it in to FSSA and include a phone number where you can be reached if we have any questions.

4. If there is a section below for "RESOURCE INFORMATION", provide bank statements or other proof of the value of the asset from within the last thirty (30) days. If your form does not ask about resources (assets), you do not need to provide any information about them.

5. 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.

6. **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. After you complete and sign your redetermination form, you can upload the form and supporting verification documents (like paystubs or bank

statements). At a minimum, you will need to submit your income from the last thirty (30) days along with the form to complete your redetermination. If this form has a section below for “RESOURCE INFORMATION” you will also need to submit proof of the value of your assets. If we need more information from you after you submit information online, we will send you a separate request.

7. If you are submitting a paper redetermination form, make sure the person it is addressed to (or their Authorized Representative on file with FSSA) signs it.

If FSSA does not receive this information, your health coverage will change after the redetermination due date on the form we send you. If you miss the due date, you can still turn in the form and information up to 90 days late and we will review you for restarting eligibility without completing a new application. If you do turn in information but are determined to be ineligible, you can reapply at any time.

If you are no longer eligible, you will get a final notice about two (2) weeks before your coverage is scheduled to change. You can appeal FSSA’s decisions, and your appeal rights will be found at the end of the final notice. **FSSA has not changed your coverage at this time, so please provide FSSA with any and all updated information you believe would help you keep your current coverage.**

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., Monday through Friday.

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 Division of Family Resources office in your county. The locations of these offices are available at www.fssa.in.gov or by calling 1-800-403-0864.

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/Healthy Indiana Plan 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

This is a 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.

IF THERE ARE CHANGES PLEASE RETURN THIS FORM AND DOCUMENTS TO US NO LATER THAN MARCH 31, 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 46204-3422		
CHANGES/CORRECTIONS				

MAILING ADDRESS:		
ADDRESS LINE1	ADDRESS LINE2	CITY, STATE ZIP
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]	01/18/1988	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
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]	odd jobs for mother	odd jobs for mother	$150.00	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]	Section 8/Housing Authority - To Vendor	$650.00	Monthly
[redacted]	HUD - Utilities	$245.00	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
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. Please be advised that failing to provide requested information could affect your eligibility for health coverage. 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.