

TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY SERVICES
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201

410-767-1463

1-800-492-5231 extension 1463

MANUAL: Medical Assistance

EFFECTIVE DATE: April 1, 2004

RELEASE NO: MR-117

ISSUED: March 2004

APPLICABILITY: approval and denial notices for ineligible or illegal aliens.

Item

Remove Pages

Insert Pages

Chapter 5 – Non-Financial Eligibility

(ineligible or illegal aliens: eligibility notice,
ineligibility notice – non-financial reasons,
ineligibility notice – financial reasons)

notices
(after 500-12f)

COMMENTS

In Chapter 5 on pages 500-8f - 500-8g about eligibility determinations for ineligible or illegal aliens (X-track), the local department is instructed to suppress the CARES eligibility approval or denial notice and to issue, instead, either the manual Notice of Eligibility or the manual Notice of Ineligibility. Since most eligibility notices are now programmed in CARES, such manual Medical Assistance approval and denial notices may no longer be available. In CARES testing, it was found that CARES is not programmed to issue notices for the X01 coverage group (children and pregnant women who qualify for the Maryland Children's Health Program—P-track—except for residency). CARES is programmed to issue notices for the X02 coverage group (emergency medical services for ineligible or illegal aliens), but the notices are incorrect. Therefore, manual approval and denial notices specific to ineligible or illegal aliens are included in this Manual Release. Local departments may xerox copies of the three notices from this Manual Release or may download an electronic version from the DHMH Internet site under "Medical Assistance Eligibility Updates", MR-117 at:

www.dhmh.state.md.us/mma/mmahome

Maryland Medical Assistance Program
Maryland Children's Health Program
NOTICE OF ELIGIBILITY

State-Funded Aliens or Emergency Medical Services for Ineligible or Illegal Aliens

Applicant's Name: _____

Date of Notice: _____

Applicant's Address: _____

Local Department: _____

Client ID: _____

Dear _____:

This is to notify you that based on the application you filed on _____, eligibility is **approved** for:

- Coverage of full Medical Assistance benefits
- Coverage of full Maryland Children's Health Program benefits

The following person or persons are covered: _____

You will receive a Medical Care Program card for each approved person. When it is time for eligibility to be redetermined, the Program will send you a packet to complete and return by a specified due date.

Eligibility is **approved** for coverage of **emergency medical services only** for the following person: _____. Eligibility is limited to services received between _____ and _____.

When this period ends, you must file a new application in order to be considered for further assistance. Full benefits under Medical Assistance (COMAR 10.09.24) or Maryland Children's Health Program (COMAR 10.09.11) are not approved because the Program's citizenship or qualified alien requirements are not met at this time. You will **not** receive a Medical Care Program card. You must show this notice and any other health insurance membership card to the provider(s) of all emergency medical services received, so they may bill Medical Assistance.

If you have any questions about this notice, call your Eligibility Case Worker at the number below. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this notice.

Sincerely,

Eligibility Case Worker

Telephone Number

Summary of Procedures for Fair Hearings

You have the right to appeal this decision within 90 days from the date of this notice.

If you think the decision is wrong, you may:

- Call your Eligibility Case Worker at the telephone number on the other side of this notice to ask about the decision.
- Request a hearing or ask for help to make this request by:
 - Calling your Eligibility Case Worker;
 - Calling the State's help line at 1-800-332-6347;
 - Visiting your local department office; or
 - Mailing or giving a written request for a hearing to your local department office.

The hearing will be scheduled at a time and place that are convenient for you. You will be expected to be present. If for any reason you cannot be present, you must notify the Office of Administrative Hearings to reschedule the hearing or to identify the person who will attend in your place. You may represent yourself, or if you wish, you may be represented by legal counsel or by a relative, friend or other person. It is not necessary, however, that someone represent you. You may bring any witnesses or documents you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of persons from the general public may be admitted to the hearing if you desire.

Prior to the hearing, you may review the documents and records that the Department will use at the time of the hearing and you can ask for the names of the witnesses the Department intends to call.

During the time before the hearing, if you have new or additional information you wish the Department to know about, you may request a reconsideration of your case by calling your case manager or Eligibility Case Worker.

Under some circumstances, the Department may pay for transportation and other costs if they are necessary for the proper conduct of the hearing.

All these procedures and a fuller explanation of the fair hearing process can be found in the state regulations, COMAR 10.01.04 and in federal regulations 42 C.F.R. § 431.200.

You may obtain free legal aid and help through various resources, such as the Legal Aid Bureau at 1-800-999-8904 or the Maryland Disability Law Center at 1-800-233-7201.

Maryland Medical Assistance Program
Maryland Children's Health Program
NOTICE OF INELIGIBILITY
SERVICES FOR INELIGIBLE OR ILLEGAL ALIENS
Non-Financial Reasons

Applicant's Name: _____

Date of Notice: _____

Applicant's Address: _____

Local Department: _____

Client ID: _____

Dear _____:

This is to notify you that based on the application you filed on _____, you have been determined **ineligible** for full Medical Assistance or Maryland Children's Health Program benefits or for coverage of emergency medical services for the reason(s) checked below:

- You are not a resident of the State of Maryland.
- The Department of Health and Mental Hygiene determined that you do not have an emergency medical condition.
- The Department of Human Resources State Review Team determined that you are not disabled.
- You failed to appear at the local department for the required interview.
- You did not provide the following required information or verifications:
Specify: _____

- Other _____

This decision is based on COMAR 10.09._____.

You may reapply at any time. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this notice.

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