NOTICE TO APPLICANT

Your application of ________________________ for RETROACTIVE MEDICAL ASSISTANCE has been reviewed.

The decision regarding eligibility for RETROACTIVE MEDICAL ASSISTANCE is shown below.

A THE FOLLOWING PERSONS ARE INCLUDED FOR THE MONTH(S) SHOWN

LINE NO.	NAME	MONTH & YEAR	MONTH & YEAR	MONTH & YEAR	MONTH & YEAR	LINE NO.	NAME	MONTH & YEAR	MONTH & YEAR	MONTH & YEAR	MONTH & YEAR

B

RETROACTIVE MEDICAL ASSISTANCE	MONTH & YEAR	MONTH & YEAR	MONTH & YEAR	MONTH & YEAR
CATEGORY				
CONTROL DIGIT				
RESOURCES	$	$	$	$
RESOURCE LIMITATION	$	$	$	$
GROSS MONTHLY INCOME	$	$	$	$
NET MONTHLY INCOME	$	$	$	$
INCURRED MEDICAL EXPENSES	$	$	$	$
ELIGIBLE FOR RETROACTIVE MEDICAL ASSISTANCE	☐ YES	☐ YES	☐ YES	☐ YES
ELIGIBLE WITH A PATIENT PAY LIABILITY OF ▶	$	$	$	$
INELIGIBLE DUE TO EXCESS RESOURCES	REGULATION	REGULATION	REGULATION	REGULATION
INELIGIBLE DUE TO EXCESS INCOME	REGULATION	REGULATION	REGULATION	REGULATION

C You are responsible under your PATIENT PAY LIABILITY for payment to the following in the amount(s) shown below:

AMOUNT	PROVIDER NAME	PROVIDER NUMBER	DATE SERVICE PROVIDED	LINE NO.	CATEGORY
$					
$					
$					

IT IS ILLEGAL FOR THE ABOVE PROVIDER (S) TO BILL THE DEPARTMENT FOR THIS AMOUNT.

D The following unpaid medical bills were used as income deductions to make you eligible for Retroactive Medical Assistance:

AMOUNT	PROVIDER NAME	TYPE OF SERVICE	DATE SERVICE PROVIDED
$			
$			
$			
$			

IT IS ILLEGAL FOR YOU TO USE YOUR MEDICAL CARD TO PAY FOR ANY OF THESE MEDICAL BILLS!

If you have other medical bills for the month(s) for which you were determined eligible, the provider(s) may submit invoices for payment by using the case information contained in this notice if they are willing to accept the payment made by the Department for the type of service rendered.

CO	RECORD NUMBER	CAT	CTR DIG	DIST

Worker ________ Telephone ________ Mailing Date ________

If you do not understand our decision or have any questions, contact your worker.

LEGAL HELP IS AVAILABLE AT

☐ CLIENT ☐ CASE RECORD COPY ☐ PROVIDER COPY ☐ OMA COPY ☐ APPEAL COPY

YOUR RIGHT TO APPEAL AND TO A FAIR HEARING

You have the right to appeal any Departmental action or failure to act and to have a hearing if you are dissatisfied with the decision regarding your eligibility for RETROACTIVE MEDICAL ASSISTANCE.

At the hearing you can present to the Hearing Officer the reasons why you think the decision of the County Assistance Office is incorrect and present evidence or witnesses in your own behalf. You have the right to represent yourself or to have anyone represent you. A staff member of the County Assistance Office will refer you for free legal help upon request.

If you need an interpreter at the hearing because you do not speak English or you have limited understanding of English, or you have a hearing impairment, the Department will arrange for an official interpreter at no cost to you. You may bring a friend or relative to assist you at the hearing, but the interpreter provided by the Department will be the official interpreter. The Department will provide reasonable or special accommodations for you if you have a hearing impairment or other disability. You must make the request for an interpreter or other accommodation in advance of the hearing.

If you and your representative would like to meet with the County Assistance Office staff to discuss the matter informally or to present information which might change the decision regarding your eligibility for retroactive medical assistance, please call your worker. This will not delay or replace your hearing.

You must request a hearing within **30 days** of the mailing date of this notice. If your request is not postmarked or received within the **30-day** time limit, your appeal will be dismissed without a hearing.

HOW TO REQUEST A FAIR HEARING:
To appeal and request a hearing for **ASSISTANCE CHECKS**, **MEDICAL ASSISTANCE** or **SOCIAL SERVICES**, you may call your worker; but, you must also put the appeal in writing as follows: **(1)** Fill out and sign one copy of this form. Give the reason for your appeal; **and** Give your telephone number; **and** Give your exact address; **and (2)** Mail or take this form to the CAO at the address on the front side of this form. To appeal and request a hearing for **FOOD STAMPS**, you may call your worker; or put the appeal in writing; or do both. If you put the appeal in writing, follow the instructions above.

PLEASE CHECK THE BOX NEXT TO THE TYPE OF HEARING YOU WANT:

☐ I want a Telephone Hearing. I and my witnesses and anyone helping me will be at this phone number: ________________________________.

☐ I want a Telephone Hearing. I and my witnesses and anyone helping me **will be at the County Assistance Office (CAO)**.

☐ I want a Face-to-Face Hearing. I and my witnesses and anyone helping me will be in the hearing room with the Judge and the caseworker and CAO staff.

☐ I want a Face-to-Face Hearing. I and my witnesses and anyone helping me will be in the hearing room with the Judge. The caseworker and other staff will be on the phone from the CAO.

PLEASE CHECK BELOW IF YOU NEED HELP BECAUSE OF A HEARING PROBLEM OR A DISABILITY OR YOU NEED AN INTERPRETER:

☐ I have a hearing impairment or a disability. Describe accommodations needed ________________________________.

☐ I need an interpreter. There will be no cost to me. What language? ________________________________.

I WANT TO REQUEST A HEARING BECAUSE:

DATE	CLIENT REPRESENTATIVE SIGNATURE	TELEPHONE #	DATE	CLIENT SIGNATURE	TELEPHONE #

CLIENT ADDRESS

HEARING LOCATIONS

PHILADELPHIA FOR:	Bucks, Chester, Delaware, Montgomery, Philadelphia.
PITTSBURGH FOR:	Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, Westmoreland.
HARRISBURG FOR:	Adams, Berks, Centre, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lancaster, Lebanon, Lycoming, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, York, Lehigh.
PLYMOUTH FOR:	Bradford, Clinton, Lackawanna, Monroe, Sullivan, Tioga, Wyoming, Carbon, Columbia, Luzerne, Pike, Susquehanna, Wayne.

☐ **CLIENT** ☐ **CASE RECORD COPY** ☐ **PROVIDER COPY** ☐ **OMA COPY** ☐ **APPEAL COPY**