



## **You May Still Have Medicaid Coverage**

If you leave Neighborhood INTEGRITY, you will receive your Medicaid, Medicare and prescription drug coverage (Medicare Part D) separately. If you still have Rhode Island Medicaid eligibility, you will be enrolled in Neighborhood UNITY for your *Medicaid* benefits. Call the Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469 (TTY 711), Monday – Friday, 8:30 am- 7:00 pm, Saturday 9:00 am- 12 noon, to find out about your coverage options.

If you moved to another state, you should contact the local Medicaid office in your new state for more information about Medicaid enrollment there.

## **If you have moved, you must report your new address to the Social Security**

**Administration.** Call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) to report your new address. TTY users should call 1-800-325-0778.

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## **Appeals Rights and Deadlines**

You have a right to a hearing if you disagree with a decision we have made. You have 30 days from the date you receive this letter to request an appeal. If you do not request an appeal, you may lose the right to a hearing. Please see the enclosed appeal form for complete instructions.

After completing Sections I and II on the enclosed form,

Please **MAIL** to:

EOHHS/ Medicare-Medicaid Plan                      [This address is for mail only.]  
Hazard Building LL B23, 74 West Road  
Cranston, RI 02920-8409

Or **FAX** to: (401) 462-3158

If you need help in person or to hand deliver your appeals form, please go to a local Rhode Island Department of Human Services (DHS) Office. If you have questions about completing the form or locating a DHS Office, please call the Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469 (TTY 711), Monday – Friday, 8:30 am- 7:00 pm, Saturday 9:00 am- 12 noon.

[Insert appeals form here]

[<Marketing Material ID: 019 DISENROLLMENT DUE TO OUT OF AREA STATUS>]



## INSTRUCTIONS FOR COMPLETING DHS-121

This form is used by both the client and the agency representative to:

1. Identify in writing by the client the cause of his/her appeal; and
2. Identify, by the agency representative, the policy on which the decision causing the appeal was based.

The client receives this form at the time of notification of an Agency decision.

**For Supplemental Nutrition Assistance Program (SNAP):** A client has **90** days from the mail date of the Notice of Agency Action to request a hearing.

**For General Public Assistance (GPA):** A client has **10** days from the mail date of the Notice of Agency Action to request a hearing.

**For All Other Programs:** A client has **30** days from the mail date of the Notice of Agency Action to request a hearing.

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### Sections I and II

These two sections can be filled out by the client alone, or by the client and agency representative, if the client needs help in completing the form. The person requesting an appeal signs this section and returns the completed form to the appropriate regional or district office.

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### Section III

After Sections I and II are completed, the agency representative completes Section III, citing the agency policy(ies) with reference to the particular manual section(s) that was the basis for making the decision. This section is signed by the agency representative and supervisor. The area identifying the local office is completed. The form is routed promptly to the hearing office at Central Office.

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**NOTE:** When the DHS-121 is completed by the client and mailed directly to Central Office, without being routed through the regional or district office, the hearing office makes a copy of the DHS-121. The original is sent to the regional or district office for completion of Section III. The DHS-121 must be returned to the hearing office at Central Office within seven (7) days.

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### Legal Help

At the scheduled hearing, you may represent yourself, or be represented by someone else such as a lawyer, a relative, a friend, or another person. If you want free legal help, call Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).

This letter includes important information about your health insurance. It is available for free in other languages and in Braille or audio CD. If you need a copy in your language or an interpreter, call: 1-844-602-3469 (TTY 711).

Esta carta contiene información importante acerca de su seguro médico. Está disponible gratuitamente en otros idiomas y en sistema braille o disco compacto/CD de audio. Si necesita una copia en su idioma o necesita un intérprete, llame al: 1-844-602-3469 (TTY 711).

Esta carta inclui informações importantes acerca do seu seguro de saúde. Está disponível grátis noutras línguas e em Braille ou CD de áudio. Se precisar de uma cópia noutra língua ou um intérprete, telefone para: 1-844-602-3469 (TTY 711).

Cette lettre contient des renseignements importants concernant votre assurance maladie. Elle est offerte gratuitement dans d'autres langues, en braille et en CD audio. Pour en obtenir un exemplaire dans votre langue, ou si vous avez besoin d'un interprète, composez le: 1-844-602-3469 (TTY 711).

В настоящем письме содержится важная информация о вашей медицинской страховке. Ее можно получить бесплатно на других языках, напечатанной шрифтом Брайля или на аудио компакт-диске. Если вам нужно получить копию на другом языке или вам необходим переводчик - звоните по телефону: 1-844-602-3469 (TTY 711).

本信含有涉及您的健康保险的重要信息。可免费提供其他语言版本、盲文或音频CD。如果您需要您的母语版或一个翻译，请致电：

ລິຂົດນີ້ ມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບປະກັນໄພສຸຂະພາບຂອງທ່ານ. ມັນມີໃຫ້ໂດຍບໍ່ເສຍຄ່າໃນພາສາອື່ນ ແລະໜັງສືໂພງສໍາລັບເຈົ້າ ແລະ ມີສຽງສຳລັບຄົນຕາບອດ ຫຼືຊິດີສຽງ. ຖ້າທ່ານຕ້ອງການສໍາເນົາເປັນພາສາຂອງທ່ານ ຫຼືຕ້ອງການລ່າມແປພາສາ, ໃຫ້ໂທ:

ຈົດໝາຍສະບັບນີ້ລວມມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບປະກັນໄພສຸຂະພາບຂອງທ່ານ. ມັນມີໃຫ້ໂດຍບໍ່ເສຍຄ່າໃນພາສາອື່ນ ແລະໜັງສືໂພງສໍາລັບຄົນຕາບອດ ຫຼືຊິດີສຽງ. ຖ້າທ່ານຕ້ອງການສໍາເນົາເປັນພາສາຂອງທ່ານ ຫຼືຕ້ອງການລ່າມແປພາສາ, ໃຫ້ໂທ:

1-844-602-3469 (TTY 711).

**Non-Discrimination**

In accordance with Federal and State laws, the Rhode Island Executive Office of Health and Human Services does not discriminate on the basis of race, color, national origin, disability, political beliefs, age, religion, gender, or sexual orientation. If you believe you have been wrongfully discriminated against, call us at 1-844-602-3469 (TTY 711) for information on how to file a complaint.

**If You Think You Received This Letter in Error**

If you think you received this letter in error (by mistake), or have questions, please contact the MMP Enrollment Line at 1-844-602-3469 (TTY 711).