RI Executive Office of Health and Human Services
Medicaid Program

<SEQ #> <NOTIFICATION ID> <DATE>
<NAME> <LAST 4 DIGITS OF THE MEMBER#>
<ADDRESS>
<CITY>, <STATE> <ZIP>

IMPORTANT: Your Medicare Coverage May Have Ended. Act Now.

Dear <Name>:

The Social Security Administration has reported to us that your Medicare coverage (either Part A, Part B, or Part D) has ended as of <date>. You must have both Medicare Part A, B, and be eligible for Part D to be a member of Neighborhood INTEGRITY.

If you think this is wrong, please call the Social Security Administration as soon as possible at 1-800-772-1213 (Monday to Friday 7am – 7pm) to have them fix your records. TTY users should call 1-800-325-0778. If you have Medicare Part A, B, and D and you would like to re-enroll in Neighborhood INTEGRITY 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, once Social Security has updated your records.

For questions about Medicare, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week or visit the website: www.medicare.gov. TTY users should call 1-877-486-2048.

You Still Have Medicaid Coverage

If you no longer have Medicare coverage (Part A, B, or D) you are not eligible for Neighborhood INTEGRITY. However, you will continue to receive your Medicaid benefits through Neighborhood UNITY.

If you have any questions about this letter or your coverage options, 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. The call is free.

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 state appeals form here]

[<Marketing Material ID: 024 DISENROLLMENT DUE TO PART A OR B ENDING>]

DHS-121
Rev.10-14

Agency Date Stamp

RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES

Hearing Office Date Stamp

REQUEST FOR A HEARING

SECTION I. IDENTIFYING INFORMATION – Please Print

Name _____ _____
Recipient Social Security Number

Address _____
Number and Street City/Town State ZIP

WHAT LANGUAGE DO YOU SPEAK? _____

SECTION II. STATEMENT OF COMPLAINT (To be completed by applicant or recipient)

MY APPEAL IS ABOUT: ____RIW ____MEDICAID ASST. ____GPA
____SNAP ____CHILD CARE _____OTHER

_____

_____

_____

_____

_____

IF THE HEARING DECISION IS NOT IN MY FAVOR, I UNDERSTAND THAT I MUST REPAY ANY ASSISTANCE AND/OR FOOD STAMPS FOR WHICH I AM DETERMINED INELIGIBLE.

Signature _____ Date _____
(Recipient)

SECTION III. STATEMENT OF AGENCY POLICY (To be completed by the Agency Representative)

THE APPEAL IS ABOUT: ____RIW ____MEDICAID ASST. ____GPA
____SNAP ____CHILD CARE ____MART DECISION

Indicate Specific DHS/FS Manual Reference: Section(s) _____ _____

Explain agency decision in relation to complaint and policy: _____

_____

_____

_____

_____ _____
Agency Representative (Signature) **Supervisor (Signature)**
(Print Name)_____ **(Print Name)**_____

Regional Manager _____ **Local Office** _____

Also Send Copies of the scheduled appointment for this Hearing Request to: _____ _____

_____ _____ _____ _____

AGENCY:
MA DISABILITY ONLY CASES: Attach Copy of InRhodes Adverse Action Notice
ALL OTHER CASES: Bring Notice to Hearing

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.

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.

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.

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.

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：

លិខិតនេះរួមមានព័ត៌មានសំខាន់អំពីការធានារ៉ាប់រងសុខភាពរបស់អ្នក។ វាមានឥតគិតថ្លៃជាភាសាផ្សេងទៀត និងជាអក្សរសម្រាប់ជនពិការភ្នែក ឬជាស៊ីឌីសំឡេង។ប្រសិនបើអ្នកត្រូវការច្បាប់ចម្លងជាភាសារបស់អ្នក ឬអ្នកបកប្រែផ្ទាល់មាត់ សូមទូរស័ព្ទមកកាន់ៈ

ຈົດໝາຍສະບັບນີ້ລວມມີຂໍ້ມູນສຳຄັນກ່ຽວກັບປະກັນໄພສຸຂະພາບຂອງທ່ານ. ມັນມີໃຫ້ໂດຍບໍ່ເສຍຄ່າໃນພາສາອື່ນ ແລະໜັງສືໂພງສຳລັບຄົນຕາບອດ ຫຼືຊີດີສຽງ. 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).