

KATIE BECKETT COVERAGE GROUP

Katie Beckett Unit

**Center for Child and Family Health
RI Department of Human Services
Hazard Building (Bldg 74) –Lower Level, 74 West Rd.
Cranston, R.I. 02920
Main Number (401) 462-5300**

PLEASE KEEP THIS COPY FOR FUTURE REFERENCE

RIGHTS AND RESPONSIBILITIES

RIGHTS

Your child has a RIGHT to request, and if found eligible, to receive Medical Assistance based on policies and standards established under State laws.

You have a RIGHT to appeal and to receive a Hearing before a Hearing Officer of the Department if you are dissatisfied with any Department decision, or if the Department delays in making a decision. If you request a Hearing, your appeal will be heard promptly. You may be represented by a lawyer or any other person you select to appear on your behalf. Hearing forms, on which you may file your complaint, are available in every local and DHS state office and from the Katie Beckett Unit. You must request a hearing within 30 days from the date you receive a written notice from Medical Assistance.

Your child has a RIGHT to non-discriminatory treatment. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794); Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.); the Age Discrimination Act of 1975; the U.S. Department of Health and Human Services implementing regulation (45 C.F.R. Parts 80 and 84) and the U.S. Department of Education implementing regulation (34 C.F.R. Parts 104 and 106); the Rhode Island Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin (Limited English Proficiency persons), age, sex, disability, religion, or political beliefs, in acceptance for or provision of services, employment or treatment in its educational and other programs and activities. Under other provisions of applicable law, DHS does not discriminate on the basis of sexual orientation, gender identity or expression.

For further information about these laws, regulations and DHS' discrimination complaint procedures for resolution of complaints of discrimination, contact DHS at 600 New London Avenue #57, Cranston, Rhode Island 02920, telephone number 462-2130 (for deaf/hearing impaired 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; and the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504 and ADA. The Director of DHS or his/her designee has the overall responsibility for DHS' civil rights compliance.

Your child has a RIGHT to LIMITED ENGLISH PROFICIENCY NOTICE. The DHS will schedule an interpreter or bilingual staff member to help you read English language notices, letters or other written information from the DHS. If you have problems obtaining an interpreter or bilingual staff services at a DHS office, please contact the Limited English Proficiency Coordinator at the RI Department of Human Services, 600 New London Avenue, Cranston, RI 02920, (401) 462-2130; for hearing impaired 711.

Your child has a RIGHT to confidentiality. The Department uses information about your child only for purposes directly related to the administration of the Medical Assistance Program and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information.

DHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care

operations in accordance with DHS notice of privacy practices.

The Department does not release information about your child without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the DHS Policy Manual. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars (\$200), or imprisonment of up to six (6) months, or both.

RESPONSIBILITIES

You have a RESPONSIBILITY to supply the Department with accurate information about your child’s income, resources and living arrangements.

You have a RESPONSIBILITY to tell us immediately, within ten (10) days) of any changes in your child’s income, resources, health insurance or any other changes that affect your child.

You have a RESPONSIBILITY to provide Social Security numbers for your child, yourself, or your spouse if you are required to, as a condition of eligibility. Your child’s Social Security number, will be used in computer matching with the Department of Homeland Security (United States Immigration and Customs Enforcement [ICE] US Citizenship and Immigration Services [USCIS]), Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Services, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your child is eligible for and receiving the correct Medical Assistance benefits. Social Security numbers are also used to prevent a person from receiving duplicate benefits under any program, to make mass changes in federal benefits easier to implement, and to determine the accuracy and reliability of information given to the Department by applicants for and recipients of assistance.

You have a RESPONSIBILITY to cooperate fully with State and Federal personnel conducting quality control reviews.

MEDICAL ASSISTANCE

I understand that pursuant to Rhode Island General Law, Sections 40-6-9, 40-6-10, or 40-8-15, without the necessity of signing any document:

-- Regarding Amounts Recoverable from a Third Party

I have assigned any and all rights to the Department of Human Services, for and on behalf of my child for whom I may legally act, for amounts recoverable from a third party equal to the amount of medical assistance provided as a result of accident, injury, or illness.

I understand that this application will serve as authorization to the Department of Human Services to obtain from Medical providers information that is pertinent to my child for as long as the case remains open.

I understand and agree that the DHS office may contact other persons or organizations to obtain the necessary proof of my child’s eligibility and level of benefits.

PENALTIES FOR PERJURY

I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of \$1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled, or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported.

I agree to give the DHS accurate information, and I give the DHS permission to obtain any appropriate documentation in order to prove my statements.

I understand and agree to notify the DHS of any changes within ten (10) days. I understand that under State and Federal law, there is a penalty for making false and misleading statements. I agree to cooperate fully with the State and Federal personnel conducting quality reviews.

I understand that Medical Assistance does not pay medical expenses that a third party is supposed to pay. I agree to provide the DHS with my and my spouse's valid Social Security Number(s), upon request, if the child is determined eligible. This information is for Third Party Liability use. I understand that by signing below, I am assigning the child's rights to any third party payment to the DHS, including payment for lawsuits, hospital and health insurance policies to cover benefits provided. I also understand that the DHS has a potential lien against the child's estate.

I know that the information I have given is confidential and used only for administration of the DHS programs. The DHS will not release information about me or the applicant child without my written consent except for the administration of the program and as provided in State law and regulations. I know that the child's eligibility will not be affected by race, color, national origin, disability, sex, age, or sexual orientation, except where this is restricted by law. If the DHS finds my child ineligible, I may reapply at any time. I know that I have the right to appeal any agency decision or delays, and receive a hearing before a DHS Hearing Officer.

The applicant child's parent or legal guardian has signed an application agreeing to these Rights and Responsibilities.

PLEASE SAVE THIS WITH THE CHILD'S RECORDS FOR FUTURE REFERENCE