CAO RETURN ADDRESS

www.dpw.state.pa.us

OFFICE OF INCOME MAINTENANCE

NOTICE

COMPASS

www.compass.state.pa.us

Notice ID:
Record Number:
District: Case Load:
Worker:
Phone: 1-
Mailing Date:
Reason: Option: Type:
Category: 1-INEL PSC: TT:

IMPORTANT INFORMATION ABOUT YOUR MEDICAL ASSISTANCE

Based on the information provided by Social Security Administration, or SSA, the person(s) listed is/are not eligible to have their Medicare Part A and/or Part B premium paid by the commonwealth. This is because your income and/or your resources exceed the limits. Single individuals may have income up to $1,218.99 and resources up to $6,600. A married couple may have combined income up to $1,639.99 and resources up to $9,910.

You are receiving this notice because the SSA gave us information that you were interested in Pennsylvania determining your eligibility for Medicare Buy-In based on your application for extra help with your Medicare Part D costs. Medicare Buy-In is a program that helps Medicare beneficiaries with limited income and assets pay their Medicare Part A and/or Part B premium.

If you are interested in applying for Medical Assistance or other benefits, please contact your local county assistance office or apply at https://www.compass.state.pa.us.

If you need help applying for Medical Assistance, or if you have questions about this notice, you can call APPRISE at 1-800-783-7067.

Citation: 55 Pa. Code §§ 140.231, 140.301 and 140.20

APPEAL AND FAIR HEARING

If you disagree with our decision, you have the right to appeal. See attached form for a complete explanation of your right to appeal and to a fair hearing.
If you are currently receiving benefits and your oral request for a hearing is received in the county assistance office, CAO, or your written request is postmarked or received on or before ____________________ your assistance will continue pending the hearing decision, except when the change is due to state or federal law.

LEGAL HELP IS AVAILABLE AT

APPLICANT NAME AND ADDRESS

CO	RECORD	DIST	CAT	PSC	TT

Notice ID:
Worker:
Phone: 1-
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CAO ADDRESS

IF YOU WISH TO APPEAL, COMPLETE THE BACK OF THIS FORM AND RETURN THE BOTTOM PORTION TO CAO.

PA 162 MI-1 3/10

SECTION A: The following person(s) are affected by the action on the front of this notice.

LINE	FIRST NAME	ACCESS/INDIVIDUAL NUMBER	V	BENEFIT PACKAGE

pennsylvania
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SECTION B: **MA Eligibility Decision:** This income covers the month period from

The following person(s) income or financial information was included for each month for the determination of your MA benefits.

Name Income						

The following calculation represents months of income:

Total Income	
Deductions	
Net Income	
Income Limit	
Patient Pay	

PATIENT PAY

You are responsible for $ patient pay amount to providers as indicated below:

Name	Date	Pay to: Provider	Amount

SPEND DOWN:

The following medical bills have been included in the deductions to determine eligibility for MA benefits for you and your family. These unpaid bills are your responsibility and will not be paid by MA.

Name of Provider	Date of Service	Amount

IF YOU WISH TO APPEAL, PLEASE COMPLETE AND RETURN THE BOTTOM PORTION OF THIS FORM

------------------------------ DETACH HERE ------------------------------

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, or 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.

For the Hearing:

- ☐ Please check if you need special help because of a hearing impairment or disability. Describe:____________________
- ☐ Please check if you need an interpreter. There will be no cost to you. What language? ____________________

I WANT TO ASK FOR A HEARING BECAUSE: (Attach more pages if you need to.)

CLIENT SIGNATURE	ADDRESS	TELEPHONE NO.	DATE
SIGNATURE CLIENT REP	**ADDRESS**	**TELEPHONE NO.**	**DATE**

YOUR RIGHT TO APPEAL AND TO A FAIR HEARING

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

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You have the right to appeal any department action or failure to act and to have a hearing if you are dissatisfied with any decision to refuse, discontinue, change, suspend, or reduce cash, Medical Assistance (MEDICAID), SNAP or Family Works services/benefits.

However, if a change in your CASH ASSISTANCE BENEFITS, FOOD STAMPS, SOCIAL SERVICES, MEDICAL ASSISTANCE (MEDICAID) or FAMILY WORKS SERVICES/BENEFITS, is caused by state or federal law requiring mass grant adjustment for classes of recipients, you will not be granted a hearing unless you are appealing the correctness of your grant computation, or the facts in your case.

If you are only challenging the law, your appeal will be dismissed by the Department but may be appealed to a higher court.

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. If you require any reasonable or special accommodation because of a hearing impairment (or other disability), the necessary arrangements will be made to provide the accommodation. 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 county assistance office staff to discuss the matter informally or to present information which might change the proposed action, please call your worker.

This will not delay or replace your fair hearing.

If the decision affects your CASH ASSISTANCE BENEFITS, SOCIAL SERVICES, MEDICAL ASSISTANCE (MEDICAID), or FAMILY WORKS SERVICES/BENEFITS, 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.

If this decision affects your SNAP benefits, you must request a hearing within 90 days from the beginning date of the change of the benefit.

If your request is not postmarked or received within the 90-day time limit, your appeal will be dismissed without a hearing.

If you are receiving CASH ASSISTANCE BENEFITS, SNAP, SOCIAL SERVICES, MEDICAL ASSISTANCE, or FAMILY WORKS SERVICES/BENEFITS and your oral or written request for a hearing is postmarked or received within 10 days of the mailing date of this notice either your benefits will continue or your benefits will be reinstated (if there was a decrease or closing of your case because of information you gave us on a semiannual reporting form) pending the outcome of the hearing. However, in those appeals where the only issue is in regard to federal or state law or policy, your benefits will be terminated when the decision is made by the Bureau of Hearings and Appeals.

If your benefits are continued and the decision is in favor of the county assistance office, any assistance you received from the date the action would have been effective to the date the hearing order is implemented must be paid back to the Department.

If you do not want your SNAP benefits to continue at the current amount pending the hearing decision, check (✓) the block in the appeal section of the advance notice.

This option does not apply to the notice to applicant or confirming notice.

Federal law limits when health coverage may be denied or limited for a pre-existing condition. Medical Assistance coverage can be credited to eliminate or reduce the pre-existing condition. If you enroll in a group or individual health plan that has a pre-existing condition exclusion, you can get credit for the time you received Medical Assistance. You may request a certificate to verify your Medical Assistance coverage. To request this certificate contact your caseworker.