
MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-305 - NOTICE OF ACTION

PURPOSE & USE

This form is used to notify applicants of the approval of an application and to notify recipients of approval of a redetermination. For institutionalized recipients, this form is used to approve a redetermination provided Medicaid Income remains the same or decreases for the current month. If Medicaid Income increases in the first month of approval of a redetermination, the recipient must be notified via DOM-306, Notice of Adverse Action, and provided 10 days advance notice. For a complete discussion of the use of this form refer to Section C.

THIS FORM IS GENERATED BY MEDS BUT IS AVAILABLE IN HARDCOPY IF NEEDED.

INSTRUCTIONS

Prepare an original and 1 copy. The original is mailed to the client or representative and the copy is filed in the case record.

This form is divided into two sections. The portion to be completed depends on the type action to be taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION: The top portion is to be completed when approving an application. Check the appropriate block to indicate the action taken.

You have been approved for Retroactive Medicaid...: Check this block if the application involves retroactive approval and specify the month(s) of retroactive eligibility in the space provided. If the applicant is being denied any month(s) of retroactive eligibility, specify in the "Remarks" section. If the retroactive approval involves month(s) of nursing home care, include the amount of Medicaid Income in the space provided.

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Note: For 1002 Retro approvals, include the following statement in the Remarks section: "You will not receive a Medicaid card for the month(s) identified above. Please show this notice to all providers of medical services that rendered services in your behalf during the month(s) shown above."

You have been approved for Medicaid beginning: Check this block if the application is being approved and enter the beginning date of eligibility.

If the recipient is in a nursing home/hospital, enter the amount of Medicaid Income and when the client must begin to pay toward the cost of his care in the spaces provided. If income protection is applicable, enter "\$0" in the first space for the first month of care and enter the amount of Medicaid Income to begin the next month in the second space provided.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE: The lower section is completed when approving a redetermination in which Medicaid Income remains the same or decreases in at least the first month. This section is also used to notify the client that his/her Medicaid case is being transferred to another Regional Office. Check the appropriate block to indicate the action taken.

The redetermination of your Medicaid case has been approved: Check this block when approving a redetermination where Medicaid Income remains the same. Enter the amount of Medicaid Income, also.

The amount you must pay . . . has been reduced: Check this block when Medicaid Income will be reduced. Enter the effective date of the reduced amount and the amount. Note, it is only necessary for the first month to reflect a decrease in Medicaid Income and not all 4 months that can be shown.

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Your case has been transferred. . .: Check this block if the client's case is being transferred to another Regional Office name the new Regional Office. Include at the bottom of the form the address and telephone number of the new Regional Office which will handle the case.

DATE OF MAILING: The Supervisor or Specialist reviewing the case will enter the date of mailing. The date entered must be the date the form is mailed out.

ADDRESS/TELEPHONE NUMBER OF REGIONAL OFFICE: Stamp or write the Regional Office address in the space provided and include the telephone number.

Signature of Medicaid Worker: The worker will sign the form in this space.

NOTICE OF ACTION

Client's Name _____

Medicaid ID # _____

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION:

- () You have been approved for Retroactive Medicaid benefits for the months listed below. If you were in the nursing home/hospital during these months, the money amount listed is the amount you must pay toward the cost of your care.

Month/Year _____ \$ _____

Month/Year _____ \$ _____

Month/Year _____ \$ _____

- () You have been approved for Medicaid beginning _____. If you are in a nursing home/hospital the amount you must pay toward the cost of care is:

Month/Year _____ \$ _____

Month/Year _____ \$ _____

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE:

- () The redetermination of your Medicaid case has been approved. You remain eligible for Medicaid benefits. Medicaid Income remains \$ _____.

- () The amount you must pay toward the cost of your nursing home/hospital care has been reduced.

Beginning _____, you will pay \$ _____

Beginning _____, you will pay \$ _____

- () Your case has been transferred to the _____ Regional Office. The address of this office is given below.

REASON/REMARKS: _____

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR CASE, you may request a fair hearing. Hearing requests must be made in writing within 30 days of the date the worker signed this form. Your written request should be mailed to the Regional Office address shown below. THIS DOES NOT APPLY TO ESTATE RECOVERY PER MISS. CODE ANN. SEC. 43-13-317.

DATE OF MAILING: _____ MEDICAID SPECIALIST: _____

REGIONAL OFFICE ADDRESS/TELEPHONE:

Enclosures: