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MEDICAID ELIGIBILITY  
FORMS AND INSTRUCTIONS

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DOM-306 - NOTICE OF ADVERSE ACTION

**PURPOSE & USE**

The purpose of this form is to notify the client of any adverse action taken on an application or active case. Adverse actions include all rejections of applications, case closures, and increases in Medicaid Income. The form explains the client's right to a hearing and the right to continuation of benefits if a hearing is timely requested to appeal an increase in Medicaid Income or termination of benefits.

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 along with a hearing pamphlet. The copy is filed in the case record. Refer to Section C for policy governing adverse actions and continuation of benefits.

The DOM-306 is divided into two sections. The correct section to complete depends on the type of action taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION: Complete the top portion of DOM-306 for a rejection of an application. In the space provided, enter the reason for the rejection which includes an explanation of the policy supporting the action taken.

THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE: Complete the lower portion of DOM-306 for either a termination of benefits (closure) or and increase in Medicaid Income, whichever is applicable. The effective date of the termination or increase will be entered in the appropriate space. Refer to Section C for policy which governs the effective dates of either type of action.

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The reason for the closure or increase will be clearly stated in the space provided. For closures, include an explanation of the policy which supports the action taken. For an increase in Medicaid Income, include the new amount to be paid and the reason for the increase.

For both terminations and increases in Medicaid Income, complete the continuation of benefits portion of the fair hearing statement. The date to be entered is 10 calendar days from the date of mailing. The Supervisor or Specialist who reviews the case and mails the form should enter the date of mailing and the date which represents the end of the 10-day advance notice period in the space provided.

DATE OF MAILING: Enter the date the form is mailed.

WORKER: The worker will sign here.

ADDRESS/TELEPHONE NUMBER OF REGIONAL OFFICE: The Regional Office address and telephone number must be stamped in the space provided.

**NOTICE OF ADVERSE ACTION**

Client's Name \_\_\_\_\_

Medicaid ID # \_\_\_\_\_

**THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID APPLICATION:**

( ) Your request for Medicaid benefits must be denied because \_\_\_\_\_

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR APPLICATION, you have 30 days from the date the worker signs this notice to request a fair hearing. A hearing pamphlet is enclosed which explains hearing procedures.

**THE FOLLOWING ACTION HAS BEEN TAKEN ON YOUR MEDICAID CASE:**

( ) Your case will close effective \_\_\_\_\_.

) You remain eligible for Medicaid, however there has been an increase in the amount you must pay toward the cost of your nursing home/hospital care.

Beginning \_\_\_\_\_, you will pay \$ \_\_\_\_\_

Beginning \_\_\_\_\_, you will pay \$ \_\_\_\_\_

Beginning \_\_\_\_\_, you will pay \$ \_\_\_\_\_

REASON: \_\_\_\_\_

IF YOU DISAGREE WITH THE ACTION TAKEN ON YOUR MEDICAID CASE, you have 30 days from the date the worker signs this notice to request a fair hearing. A hearing pamphlet is enclosed which explains hearing procedure.

If you request a hearing by \_\_\_\_\_, you can continue to receive Medicaid, or receive it at your current level, during the hearing process. 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: Hearing Pamphlet