
MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-309 - SECOND REQUEST FOR INFORMATION

PURPOSE & USE

This form is used as a second request when the information requested via DOM-307 was not provided by the end of the 10-day period specified. The second request informs the client or representative of the information still needed to complete the application or redetermination process.

THIS FORM IS AVAILABLE IN MEDS.

INSTRUCTIONS

Prepare an original and 1 copy. Issue the original to the client or representative and retain the copy in the tickler file. If the original is returned with the information, discard the copy and file the original and the information in the case record. If the original is not returned but the information requested is submitted, file the copy in the case record. If the requested information is not submitted within ten (10) days, file the tickler copy in the case record. The DOM-309 original or copy must be retained in the case record to confirm the second request for information.

In the space provided, enter the information requested via DOM-307, Request for Information, that has not been received.

Check the appropriate block to indicate whether the request involves an application or redetermination in process.

Applications - Enter the applicable standard of promptness of either 45 or 60 days in the space provided. Also enter the date the 45 or 60-day period will end as determined by the date application was filed. In the last space, enter the date which is ten (10) days following the date DOM-309 is mailed.

Redetermination - In the space provided, enter the date which is ten (10) days following the date DOM-309 is mailed.

The worker will sign, date and return address stamp the form.

SECOND REQUEST FOR INFORMATION

Client's Name _____

Medicaid ID # _____

On _____, you were mailed a request for the following information:

We must have this information to complete the Medicaid application for the above named applicant. The processing time of _____ days that Medicaid is allowed to complete the application and determine eligibility ends on _____. If we do not receive the needed information by _____, appropriate action will be taken to deny the application.

We must have this information to continue Medicaid eligibility for the above named client. As of this date, we have not received this information. If we do not receive the needed information by _____, appropriate action will be taken to close the client's Medicaid Case.

Regional Office Address/Telephone:

Medicaid Specialist _____

Date _____