Xxxxxx Regional Office
0000 Xxxxxx Xx
Xxxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Client Name: Xxxxxxxx X. Xxxxxx
Medicaid ID: 000-00-0000

Xxxxxxxxx X. Xxxxxx
0000 Xxxxx Xx
Xxxxxx, MS 00000-0000

CASE WORKER CORRESPONDENCE

Dear Xxxxxxxx X. Xxxxxxx:

I received a Family Planning application from you that only contained the first page of the agreement. It was not signed. If you wish to apply for family planning you need to send in the 2nd page of the agreement with a signature.

Also, please submit check stubs for the month of May.

If not working please list your last employer and the end date of employment.

How are you currently meeting your day to day needs if not employed?

Case Worker: **Xxxxx X. Xxxxxxx** Date: **MM/DD/YYYY**
Phone: **(000) 000-0000**
Fax: **(000) 000-0000**

Notice of Non-Discrimination

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The Mississippi Division of Medicaid:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, toll-free: 800-368-1019, TDD: 800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak another language, assistance services are available to you free of charge. Call 1-800-421-2408 (TTY: 711).

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Punjabi | ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-800-421-2408 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Italian | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-421-2408 (TTY: 711).

Hindi | ध्यान दें: यदि आप कोई और भाषा बोलते हैं, तो सहायता सेवाएं आप के लिए नि: शुल्क उपलब्ध हैं। 1-800-421-2408 (TTY: 711) पर कॉल करें।

Xxxxxx Regional Office
0000 Xxxxxxxxx Xxxxx
Xxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxx Xxxxxxxx
0000 Xxxxxxxx Xx
Xxxxxx, MS 00000-0000

Case Number :**000000000**

ACTIONS HAVE BEEN TAKEN ON YOUR HEALTH BENEFITS APPLICATION/CASE

Xxxx X Xxxxxxxx **Medicaid ID#:000-00-0000**

Effective MM/DD/YYYY, this individual remains eligible for Medicare cost-sharing benefits as a Qualified Medicare Beneficiary (QMB). Medicaid will continue to pay the Medicare premium(s), deductibles and co-insurance charges under Medicare Parts A & B.

The Division of Medicaid's records show the following information about you that was used to make your eligibility decision. This information was based on your application and from other data sources. Review the information below and if any of it is incorrect, you must report what has changed to your caseworker.

Name: Xxxx X Xxxxxxxx
Address: 0000 Xxxxxxx Xx Xxxxxx, MS 00000-0000
Phone Number: (000)000-0000
Marital Status: Xxxxxx

Medicare Information:

Medicare Part A starting MM/DD/YYYY to Ongoing
Medicare Part B starting MM/DD/YYYY to Ongoing

Income Information:

Member Name	Beginning	Ending	Income Type	Income Amount	Frequency
Xxxxx X Xxxxxx	MM/DD/YYYY	Ongoing	Xxxxxx Benefit (RSDI)	$$$$.$$	Xxxxxxx

IF YOU DISAGREE WITH THE ACTION TAKEN ON MEDICAID DECISIONS FOR ANY PERSON NAMED ON THIS NOTICE, you may request a fair hearing. Hearing requests must be made

within 30 days from the date of mailing on this notice. However, if any person named in this notice already has Medicaid or CHIP coverage, that person can keep their coverage if a hearing is requested within 15 days of the date of mailing on this notice. A hearing pamphlet is enclosed which explains how to request a fair hearing and other hearing procedures.

Changes in your circumstances must be reported. A change reporting pamphlet is included with this notice and tells you the types of changes which must be reported for Medicaid eligibility.

If you wish to register to vote or change your voter registration information, please contact your regional office and ask for a voter registration form to be sent to you.

Medicaid Specialist: **Xxxxx X. Xxxxx** Date: **MM/DD/YYYY**
Phone: **(000) 000-0000**
Fax: **(000)000-0000**

Enclosures: Xxxxxxxxxxxxxxx
Xxxxxxxxxxxxxxx
Xxxxxxxxxxxxxxx

MISSISSIPPI DIVISION OF MEDICAID

Medicaid and CHIP Reporting Requirements

Medicaid and CHIP recipients, or their parent or person acting in their behalf, must report changes that could affect Medicaid or CHIP eligibility. **Report the following changes within 10 days of the change:**

- A change in the source or amount of income the household receives. This can be an increase or decrease in income from wages, self-employment or any type of income received such as retirement benefits, contributions, state or federal benefits or other income received within the household.
- A change in address or a change in someone's living arrangement, such as a Medicaid or CHIP recipient moves in or out of the household or enters or leaves a nursing or medical facility.
- A change in family size due to marriage, divorce, death or a child moves into or out of the household.
- For aged, blind or disabled individuals, report any changes in what a household member owns. If a Medicaid recipient buys, sells or gives away anything of value that he/she owns, the change must be reported. Resources include property someone owns or has an interest in including home property, money in the bank or on hand, stocks, bonds or any item of value.
- For aged, blind or disabled individuals, any improvements in disability, especially improvements that affect Medicare entitlement or disability benefits must be reported.

ATTENTION CHIP RECIPIENTS WHO HAVE OTHER INSURANCE COVERAGE

Only uninsured children (with no other private or group health insurance) may qualify for CHIP. If your child is currently covered by other health insurance or becomes covered while on CHIP, he/she is not eligible for CHIP. If your child has or is added to other private or group health insurance, you must report this within 10 days of the change. The Division of Medicaid pays a premium to the CHIP separate health plan each month a child is covered by CHIP. If other health insurance coverage is not reported timely, you will be required to repay the premiums paid by the Division of Medicaid even if your child did not go to a doctor or other medical provider during the time your child was ineligible for CHIP.

Please note, if your child has only dental, vision or other health coverage that provides only limited benefits, this does not make your child ineligible for CHIP. However, this coverage must be reported.

ATTENTION MEDICAID RECIPIENTS WHO HAVE OTHER INSURANCE COVERAGE

Any change in other health insurance coverage must be reported. If someone on Medicaid has or is added to other private or group health insurance, you must report this within 10 days of the change.

ATTENTION MEDICAID RECIPIENTS ENROLLED IN MISSISSIPPICAN

If you are enrolled in MississippiCAN, the Division of Medicaid pays a monthly fee to the health plan in which you or your child is enrolled in order to manage your healthcare. If you or your child is found to be ineligible for Medicaid due to a change that was not reported timely, you will be required to repay the fees paid by the Division of Medicaid to the managed care health plan even if you and/or your child did not go to a doctor or other medical provider during the time you and/or your child was ineligible for Medicaid.

ATTENTION MEDICAID RECIPIENTS ELIGIBLE FOR MEDICAID IN A NURSING FACILITY

The amount of money you must pay toward the cost of your care (Medicaid Income) can be reduced if you have non-covered medical expenses you must pay that will not be paid by Medicaid, Medicare or other insurance. Allowable deductions include health insurance premiums, including certain Medicare premiums, and medically necessary care, services or items that are prescribed by a medical professional but not covered or fully covered by insurance. Certain expenses have a limit on the amount that can be allowed.
To claim non-covered medical expenses, present proof of the expense(s), such as a copy of the bill after all other insurance has paid. Provide proof of the expense(s) no later than the month following the month of the final billing of the expense (after all other insurance has paid).

NOTE: When cost of care is reduced to allow for non-covered medical expenses, the funds must be used for the intended purpose.

CHANGES MAY BE REPORTED AS FOLLOWS:

- Call the Regional Office that handles your case at the number shown on the attached list or on your notice.
- Fax a written statement reporting needed changes to the Regional Office that handles your case at the number shown on the attached list.
- Call the Office of Eligibility at 1-800-421-2408 to report the needed change.

Failure to report required changes that affect your eligibility for Medicaid or your child's eligibility for Medicaid or CHIP will result in the Division of Medicaid seeking repayment from you for all fees or premiums paid by Medicaid or CHIP and any healthcare costs paid directly by Medicaid or CHIP during the time you and/or your child is determined ineligible for Medicaid or CHIP.

Location	Address	Counties	Phone	Fax
Brandon	3035 Greenfield Road, Pearl, MS 39208	Rankin, Simpson, Smith	601-825-0477	601-825-2184
Brookhaven	1372 Johnny Johnson Drive, Brookhaven, MS 39601	Copiah, Lawrence, Lincoln	601-835-2020	601-833-5429
Canton	5360 I-55 North, Jackson, MS 39211	Madison, North Hinds	601-978-2399	601-956-4264
Clarksdale	520 South Choctaw Street, Clarksdale, MS 38614-4800	Coahoma, Quitman, Tunica	662-627-1493	662-627-5460
Cleveland	211 North Chrisman Avenue, Cleveland, MS 38732-2715	Bolivar, Sunflower	662-843-7753	662-843-4609
Columbia	501 Eagle Day Avenue, Suite A, Columbia, MS 39429	Covington, Jeff Davis, Marion	601-731-2271	601-736-7924
Columbus	603 Leigh Drive, Columbus, MS 39705	Lowndes, Monroe	662-329-2190	662-329-8581
Corinth	2619 South Harper Road, Corinth, MS 38834-6750	Alcorn, Prentiss, Tishomingo	662-286-8091	662-287-9763
Greenville	585 Tennessee Gas Road, Ash Bayou Mini-Mall, Suite 10, Greenville, MS 38701-8143	Washington	662-332-9370	662-334-4577
Greenwood	805 West Park Avenue, Suite 6, Greenwood, MS 38930-2832	Carroll, Leflore, Tallahatchie	662-455-1053	662-459-9754
Grenada	1109 Sunwood Drive, Grenada, MS 38901-6601	Grenada, Calhoun, Montgomery, Yalobusha	662-226-4406	662-226-8821
Gulfport	10298 Corporate Drive, Gulfport, MS 39503	Harrison	228-863-3328	228-868-0121
Hattiesburg	6971 Lincoln Road Extension, Hattiesburg, MS 39402	Forrest, Lamar, Perry	601-264-5386	601-261-1244
Holly Springs	545 J. M. Ash Drive, Holly Springs, MS 38635-2109	Lafayette, Marshall	662-252-3439	662-252-6843
Jackson	5360 I-55 North, Jackson, MS 39211	Hinds	601-978-2399	601-956-4264
Kosciusko	160 Highway 12 West, Kosciusko, MS 39090	Attala, Choctaw, Leake	662-289-4477	662-289-9420
Laurel	1100 Hillcrest Drive, Laurel, MS 39440-4731	Greene, Jones, Wayne	601-425-3175	601-425-9441
McComb	301 Apache Drive, McComb, MS 39648-6309	Amite, Pike, Walthall	601-249-2071	601-249-4629
Meridian	3848 Old Highway 45 North, Meridian, MS 39301-1517	Clarke, Lauderdale	601-483-9944	601-486-2988
Natchez	103 State Street, Natchez, MS 39120-3468	Adams, Franklin, Jefferson, Wilkinson	601-445-4971	601-445-8161
New Albany	850 Denmill Road, New Albany, MS 38652	Benton, Pontotoc, Tippah, Union	662-534-0441	662-534-7196
Newton	9423 Eastside Drive Extension, Newton, MS 39345-8063	Jasper, Newton, Scott	601-635-5205	601-635-5213
Pascagoula	1702 Denny Avenue, Pascagoula, MS 39567	George, Jackson	228-762-9591	228-762-7309
Philadelphia	340 West Main Street, Philadelphia, MS 39350-2348	Kemper, Neshoba, Noxubee, Winston	601-656-3131	601-656-7950
Picayune	1845 Cooper Road, Picayune, MS 39466-2845	Hancock, Pearl River, Stone	601-798-0831	601-798-6753
Senatobia	2776 Highway 51 South, Senatobia, MS 38668-9403	DeSoto, Panola, Tate	662-562-0147	662-562-7897
Starkville	313 Industrial Park Road, Starkville, MS 39759-3993	Chickasaw, Clay, Oktibbeha, Webster	662-323-3688	662-324-1872
Tupelo	1742 McCullough Boulevard, Tupelo, MS 38801-7101	Itawamba, Lee	662-844-5304	662-840-9941
Vicksburg	3401 Halls Ferry Road, Suite 1, Vicksburg MS 39180	Claiborne, Issaquena, Sharkey, Warren	601-638-6137	601-638-7186
Yazoo City	110 North Jerry Clower Boulevard, Suite A, Yazoo City, MS 39194	Holmes, Humphreys, Yazoo	662-746-2309	662-746-2645

MISSISSIPPI DIVISION OF MEDICAID

Eligibility Hearings

What are my rights before, during, and after a hearing?

You, or the person you choose to represent you, have the following rights:

- You have the right to read everything in your case record which is kept on file at the Medicaid Regional Office. The case record has all the documents used by the Division of Medicaid to make an eligibility decision. You may look at this file anytime during the hearing process.
- You have the right to have a lawyer help you during the hearing.
- You have the right to have witnesses testify for you.
- You have the right to present evidence which may help your case at the hearing and discuss the facts about your situation.
- You have the right to explain your case without any interference.
- You have the right to question or refute any testimony or evidence and to question any witness.
- You have the right to an expedited hearing if there is a medically urgent treatment or procedure scheduled or needed and you are uninsured.

The Division of Medicaid complies with all state and federal policies which prohibit discrimination on the basis of race, age, sex, national origin, handicap or disability- as defined through the Americans with Disabilities Act of 1990.

What is an Eligibility Hearing?

An eligibility hearing is a legal process that you may ask for if you do not agree with a decision made by the Division of Medicaid about your eligibility.

How do I ask for a hearing?

If you disagree with the action taken by the Division of Medicaid for any of the individuals shown on your notice, you may request a local and/or state hearing, as described below. If you have questions or need assistance, call the Medicaid Regional Office at the number provided below or the Office of Eligibility at 1-800-421-2408.

Hearing requests can be made in one of the following ways: in person, by mail, by telephone, or through other commonly available electronic means to the Medicaid Regional Office shown on your notice.

You must request a local or state hearing before 30 days from the date of mailing on your notice. However, this deadline may be extended if you can show good cause for not filing your request within 30 days. If any person named in this notice already has Medicaid or CHIP, that person can keep their coverage if you ask for a hearing within 15 days of the date of mailing on your notice. However, if the Division of Medicaid's action is upheld by the hearing decision, the agency has the right to initiate action for recovering benefits received during the hearing process.

Local and/or state hearings are held by telephone unless, at the hearing officer's discretion, an in-person hearing is deemed necessary.

What is the difference between local hearings and state hearings?

A **local hearing** is an informal review of your case, usually conducted by a supervisor in the Medicaid Regional Office. The hearing will not be held by a supervisor that handled the action taken on your case. At the local hearing you will be able to present additional or new information that could affect your case, ask questions about actions taken on your case and have the eligibility rules explained to you. Once the local hearing has been held, the supervisor who

heard the case will make a decision based on the facts of the case and notify you in writing of the decision. If you do not agree with the local hearing decision, you can then request a state hearing.

Exception: If the issue involves a disability or blindness denial or termination or a level of care denial for a disabled child living at home, a state hearing must be held.

A **state hearing** is much like a local hearing except that your case will be reviewed by a State Hearing Officer who has not been involved with your case before the hearing and the hearing will be recorded. After the hearing has been held, the Director of the Division of Medicaid will issue a decision based on the facts of the case and the recommendations of the State Hearing Officer. The state hearing decision is final within the Division of Medicaid. You cannot ask for another hearing on the same issue; however, you can seek judicial review in a court of appropriate jurisdiction.

How will I know when my hearing has been scheduled?

You will get a letter in the mail telling you the time and date of the hearing. If you are not able to talk on that date, you should call the Medicaid Regional Office (if you requested a local hearing) or the State Hearing Officer at the number on your letter as soon as possible to set another date.

The Division of Medicaid has 90 days to make a hearing decision.

Expedited Hearing

You may request an expedited (faster) hearing if you have an immediate need for a health service such as a medical procedure or treatment that has been scheduled or needs to be scheduled and you are uninsured. You can request an expedited hearing by contacting your local regional office in person, by mail, by telephone or through other commonly available electronic means. We will let you know if your request is granted or denied. If your expedited hearing request is granted, the timeframe for a decision is 7 working days. If your request for an expedited hearing is denied, your hearing request will follow the standard hearing timeframe of ninety (90) days.

Regional Offices

If you have questions about eligibility or how to apply for Medicaid, call your nearest Medicaid Regional Office in:

Brandon	(601) 825-0477
Brookhaven	(601) 835-2020
Canton	(601) 978-2399
Clarksdale	(662) 627-1493
Cleveland	(662) 843-7753
Columbia	(601) 731-2271
Columbus	(662) 329-2190
Corinth	(662) 286-8091
Greenville	(662) 332-9370
Greenwood	(662) 455-1053
Grenada	(662) 226-4406
Gulfport	(228) 863-3328
Hattiesburg	(601) 264-5386
Holly Springs	(662) 252-3439
Jackson	(601) 978- 2399
Kosciusko	(662) 289-4477
Laurel	(601) 425-3175
McComb	(601) 249-2071
Meridian	(601) 483-9944
Natchez	(601) 445-4971
New Albany	(662) 534-0441
Newton	(601) 635- 5205
Pascagoula	(228) 762-9591
Philadelphia	(601) 656-3131
Picayune	(601) 798-0831
Senatobia	(662) 562-0147
Starkville	(662) 323-3688
Tupelo	(662) 844-5304
Vicksburg	(601) 638-6137
Yazoo City	(662) 746-2309

Office of the Governor
Division of Medicaid
550 High St, Suite 1000
Jackson, Mississippi 39201

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The Mississippi Division of Medicaid:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, toll-free: 800-368-1019, TDD: 800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Vietnamese | CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-421-2408 (TTY: 711).

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Arabic | ملحوظة: إذا كنت تتحدث باللغة العربية، فسيتم توفير خدمات المساعدة بدون رسوم. اتصل بالرقم 1-800-421-2408 (رقم هاتف الصم والبكم: ٧١١).

Choctaw | Ho hakloh! Annopa ila ish anópolih ihokma, chiyápila hinakat oklah máyah. Iyallít ikshoh. Ipayah 1-800-421-2408 (TTY: 711).

Tagalog | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-421-2408 (TTY: 711).

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Gujarati | **સુચના: જો તમે ગુજરાતી બોલતા હો, તો ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-800-421-2408 (TTY: 711) પર ફોન કરો.**

Japanese | 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-421-2408（TTY: 711）まで、お電話にてご連絡ください。

Russian | ВНИМАНИЕ! Если вы говорите на русском языке, вам могут быть бесплатно предоставлены услуги перевода. Звоните по телефону 1-800-421-2408 (телетайп: 711).

Punjabi | ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-800-421-2408 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Italian | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-421-2408 (TTY: 711).

Hindi | ध्यान दें: यदि आप कोई और भाषा बोलते हैं, तो सहायता सेवाएं आप के लिए नि: शुल्क उपलब्ध हैं। 1-800-421-2408 (TTY: 711) पर कॉल करें।

Brandon Regional Office
3035 Greenfield Rd.
Pearl, MS 39208

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxx X Xxxxxx
000 Xxxxxxxx Xx
Xxxxx, MS 00000-0000

Case Number : **000000000**

ACTIONS HAVE BEEN TAKEN ON YOUR HEALTH BENEFITS APPLICATION/CASE

8ØØØØØ 8 8ØØØØ **Medicaid ID#:ππ0-ππ-ππππ**

As of 00/00/0000, this individual will no longer be eligible for Medicaid because of failure to comply with redetermination requirements.

The Division of Medicaid made this decision based on 42 CFR 435.916.

The Division of Medicaid's records show the following information about you that was used to make your eligibility decision. This information was based on your application and from other data sources. Review the information below and if any of it is incorrect, you must report what has changed to your caseworker.

Name: Xxxxx X Xxxxxx
Address: 000 Xxxxxxxxx X Xxxxxx, MS 00000-0000
Phone Number: (000) 000-0000
Marital Status: Xxxxx

This individual qualifies to be reinstated for Medicaid through the COVID-19 public health emergency. You will be receiving a second notice detailing this temporary coverage within the next few days.

Xxxx X Xxxxx **Medicaid ID#: 000-00-0000**

As of 00/00/0000, this individual will no longer be eligible for Medicaid because of failure to comply with redetermination requirements.

The Division of Medicaid made this decision based on 42 CFR 435.916.

This individual qualifies to be reinstated for Medicaid through the COVID-19 public health emergency. You will be receiving a second notice detailing this temporary coverage within the next few days.

Xxxxx X Xxxxxx **Medicaid ID#: 000-00-0000**

As of 00/00/0000, this individual will no longer be eligible for Medicaid because of failure to comply with redetermination requirements.

The Division of Medicaid made this decision based on 42 CFR 435.916.

This individual qualifies to be reinstated for Medicaid through the COVID-19 public health emergency. You will be receiving a second notice detailing this temporary coverage within the next few days.

IF YOU DISAGREE WITH THE ACTION TAKEN ON MEDICAID DECISIONS FOR ANY PERSON NAMED ON THIS NOTICE, you may request a fair hearing. Hearing requests must be made in writing within 30 days from the date of mailing on this notice. However, if any person named in this notice already has Medicaid or CHIP coverage, that person can keep their coverage if a hearing is requested within 15 days of the date of mailing on this notice. A hearing pamphlet is enclosed which explains hearing procedures.

If anyone in this case is pregnant, has a new baby, is breast feeding, or has a child less than age 5, contact your local health department about WIC (Women, Infants, and Children) benefits and services.

Medicaid Specialist: **Xxxxxx X. Xxxxxx** Date: **0/0/0000**
Phone: **(000) 000-0000**
Fax: **(000) 000-0000**

Enclosures: Fair Hearing Pamphlet
Notice of Non-Discrimination Flyer

MISSISSIPPI DIVISION OF MEDICAID

Eligibility Hearings

What are my rights before, during, and after a hearing?

You, or the person you choose to represent you, have the following rights:

- You have the right to read everything in your case record which is kept on file at the Medicaid Regional Office. The case record has all the documents used by the Division of Medicaid to make an eligibility decision. You may look at this file anytime during the hearing process.
- You have the right to have a lawyer help you during the hearing.
- You have the right to have witnesses testify for you.
- You have the right to present evidence which may help your case at the hearing and discuss the facts about your situation.
- You have the right to explain your case without any interference.
- You have the right to question or refute any testimony or evidence and to question any witness.
- You have the right to an expedited hearing if there is a medically urgent treatment or procedure scheduled or needed and you are uninsured.

The Division of Medicaid complies with all state and federal policies which prohibit discrimination on the basis of race, age, sex, national origin, handicap or disability- as defined through the Americans with Disabilities Act of 1990.

What is an Eligibility Hearing?

An eligibility hearing is a legal process that you may ask for if you do not agree with a decision made by the Division of Medicaid about your eligibility.

How do I ask for a hearing?

If you disagree with the action taken by the Division of Medicaid for any of the individuals shown on your notice, you may request a local and/or state hearing, as described below. If you have questions about how to request a hearing, call the Medicaid Regional Office at the number provided below or call the Office of Eligibility at 1-800-421-2408 and we will explain how to put your request in writing.

Hearing requests must be made in writing. To request a hearing, write your own statement and mail, fax or bring it to the Medicaid Regional Office shown on your notice. Be sure to tell us if you want a local or state hearing.

You must request a hearing before 30 days from the date of mailing on your notice. However, this deadline may be extended if you can show good cause for not filing your request within 30 days. If any person named in this notice already has Medicaid or CHIP, that person can keep their coverage if you ask for a hearing within 15 days of the date of mailing on your notice. However, if the Division of Medicaid's action is upheld by the hearing decision, the agency has the right to initiate action for recovering benefits received during the hearing process.

Local and/or state hearings are held by telephone unless, at the hearing officer's discretion, an in-person hearing is deemed necessary.

What is the difference between local hearings and state hearings?

A **local hearing** is an informal review of your case, usually conducted by a supervisor in the Medicaid Regional Office. The hearing will not be held by a supervisor that handled the action taken on your case. At the local hearing you will be able to present additional or new information that could affect your case, ask questions about actions taken on your case and have the eligibility rules explained to you. Once

the local hearing has been held, the supervisor who heard the case will make a decision based on the facts of the case and notify you in writing of the decision. If you do not agree with the local hearing decision, you can then request a state hearing.

Exception: If the issue involves a disability or blindness denial or termination or a level of care denial for a disabled child living at home, a state hearing must be held.

A **state hearing** is much like a local hearing except that your case will be reviewed by a State Hearing Officer who has not been involved with your case before the hearing and the hearing will be recorded. After the hearing has been held, the Director of the Division of Medicaid will issue a decision based on the facts of the case and the recommendations of the State Hearing Officer. The state hearing decision is final within the Division of Medicaid. You cannot ask for another hearing on the same issue; however, you can seek judicial review in a court of appropriate jurisdiction.

How will I know when my hearing has been scheduled?

You will get a letter in the mail telling you the time and date of the hearing. If you are not able to talk on that date, you should call the Medicaid Regional Office (if you requested a local hearing) or the State Hearing Officer at the number on your letter as soon as possible to set another date.

The Division of Medicaid has 90 days to make a hearing decision.

Expedited Hearing

You may request an expedited (faster) hearing if you have an immediate need for a health service such as a medical procedure or treatment that has been scheduled or needs to be scheduled and you are uninsured. You can request an expedited hearing in person, by mail or by faxing the request to your local regional office. We will let you know if your request is granted or denied. If your expedited hearing request is granted, the timeframe for a decision is 7 working days. If your request for an expedited hearing is denied, your hearing request will follow the standard hearing timeframe of ninety (90) days.

Regional Offices

If you have questions about eligibility or how to apply for Medicaid, call your nearest Medicaid Regional Office in:

Brandon	(601) 825-0477
Brookhaven	(601) 835-2020
Canton	(601) 978-2399
Clarksdale	(662) 627-1493
Cleveland	(662) 843-7753
Columbia	(601) 731-2271
Columbus	(662) 329-2190
Corinth	(662) 286-8091
Greenville	(662) 332-9370
Greenwood	(662) 455-1053
Grenada	(662) 226-4406
Gulfport	(228) 863-3328
Hattiesburg	(601) 264-5386
Holly Springs	(662) 252-3439
Jackson	(601) 978- 2399
Kosciusko	(662) 289-4477
Laurel	(601) 425-3175
McComb	(601) 249-2071
Meridian	(601) 483-9944
Natchez	(601) 445-4971
New Albany	(662) 534-0441
Newton	(601) 635- 5205
Pascagoula	(228) 762-9591
Philadelphia	(601) 656-3131
Picayune	(601) 798-0831
Senatobia	(662) 562-0147
Starkville	(662) 323-3688
Tupelo	(662) 844-5304
Vicksburg	(601) 638-6137
Yazoo City	(662) 746-2309

Office of the Governor
Division of Medicaid
550 High St, Suite 1000
Jackson, Mississippi 39201

Notice of Non-Discrimination

The Mississippi Division of Medicaid complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Mississippi Division of Medicaid:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Mississippi Division of Medicaid has discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 550 High Street Suite 1000, Jackson, MS 39201, toll-free: 1-800-421-2408, fax: 601-359-6294, email: civilrights@medicaid.ms.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, toll-free: 800-368-1019, TDD: 800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak another language, assistance services are available to you free of charge. Call 1-800-421-2408 (TTY: 711).

Spanish | ATENCIÓN: si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia. Llame al 1-800-421-2408 (TTY: 711).

Vietnamese | CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-421-2408 (TTY: 711).

Chinese | 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-800-421-2408（TTY：711）

French | ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-421-2408 (ATS : 711).

Arabic | ملحوظة: إذا كنت تتحدث باللغة العربية، فسيتم توفير خدمات المساعدة بدون رسوم. اتصل بالرقم 1-800-421-2408 (رقم هاتف الصم والبكم: ٧١١).

Choctaw | Ho hakloh! Annopa ila ish anópolih ihokma, chiyápila hinakat oklah máyah. Iyallít ikshoh. Ipayah 1-800-421-2408 (TTY: 711).

Tagalog | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-421-2408 (TTY: 711).

German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-421-2408 (TTY: 711).

Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-421-2408(TTY: 711) 번으로 전화해 주십시오.

Gujarati | **સુચના: જો તમે ગુજરાતી બોલતા હો, તો ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-800-421-2408 (TTY: 711) પર ફોન કરો.**

Japanese | 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-421-2408（TTY: 711）まで、お電話にてご連絡ください。

Russian | ВНИМАНИЕ! Если вы говорите на русском языке, вам могут быть бесплатно предоставлены услуги перевода. Звоните по телефону 1-800-421-2408 (телетайп: 711).

Punjabi | ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-800-421-2408 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Italian | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-421-2408 (TTY: 711).

Hindi | ध्यान दें: यदि आप कोई और भाषा बोलते हैं, तो सहायता सेवाएं आप के लिए नि: शुल्क उपलब्ध हैं। 1-800-421-2408 (TTY: 711) पर कॉल करें।

Xxxxxxx Regional Office
0000 Xxxxxxxxxx Xx
Xxxxxxx, MS 00000-0000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxxx Xxxxx
0000 Xxxxxxxx Xx
Xxxxxxx, MS 00000

Child's Name: Xxxxx X. Xxxxx
Medicaid ID: 000-00-0000

DISABLED CHILD LIVING AT HOME (DCLH) REQUEST FOR INFORMATION

The medical and institutional level of care information required to process a DCLH application, or determine continued DCLH eligibility, is discussed below. Please provide the medical form in Item 1 and required documentation in Item 2 for the level of care that applies to the above child before **MM/DD/YYYY**.

1. **Disabled Child Living at Home Pediatric Medical Necessity/Level of Care Statement (Attached).** A fully completed pediatric medical necessity/level of care form is required for all level of care decisions. The Medical Necessity/Level of Care Statement, with instructions for completion and information on level of care criteria and required documentation is attached. It must be completed by a doctor who regularly treats the child's medical condition. The physician (and as indicated, the primary caregiver) must sign/date the form on page 2.

2. **Required Documentation for Level of Care Indicated by Child's Physician**. All documents, case/therapy notes, test scores, etc., required for the institutional level of care that is being recommended by the child's treating physician must be provided, as follows:

   - If **Level of Care = Nursing Facility Level of Care**, provide:
     - Physician Order for Nursing and/or Rehab Therapy for most recent 3 months,
     - Nursing Notes and/or Rehab Notes for most recent 3 months (if applicable)
     - IEP or IFSP (if in effect),
   - If **Level of Care = Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Level of Care**, provide:
     - Developmental Evaluation *with Score* from past 3 years **(for ages 0-5)** or
     - Psychological Evaluation *with Score* from past 3 years **(for ages 6 and up)** and
     - IEP or IFSP (if in effect).
   - If **Level of Care = Hospital Level of Care**, provide:
     - Physician Order for Nursing and/or Rehab Therapy for most recent 3 months, and
     - Nursing Notes and/or Rehab Notes for most recent 3 months
     - Hospital Records, if available.

Case Worker: **Xxxxxxxx X. Xxxxxx** Date: **MM/DD/YYYY**
Phone: **(000) 000-0000**
Fax: **(000) 000-0000**

Disabled Child Living at Home (DCLH) Medical Necessity/Level of Care Statement

Member Name: _____ DOB: _____ SS#: _____

Diagnosis: _____

_____

DCLH Criteria The child must meet an Institutional Level of Care (LOC) at the time of application. The three (3) Institutional LOCs are Nursing Facility LOC, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) LOC, and Hospital LOC. Refer to the DCLH Medicaid Necessity Level of Care Statement Criteria and Requirements section on page 3 for information on each institutional LOC and the required documents for each.

Physician Recommended level of Care: (Check the box next to the level of care recommended for this child and provide all required documents applicable to that Level of Care indicated on page 3.)

_____ Hospital Level of Care
_____ Nursing Facility Level of Care
_____ Level of Care required in an Intermediate Care Facility for ID (ICF-ID)
_____ N/A – Not Applicable

***If a Level of Care is not recommended this will result in a denial.*

Medical History: (May attach hospital discharge summary or provide narrative) _____

_____

_____

Medications			
Name	Dosage	Route	Frequency

Current Needs

Description of Skilled Nursing Needs

Cardiovascular: _____ _____
Neurological: _____ _____
Respiratory: _____ _____
Nutrition: _____ _____
Integumentary: _____ _____
Urogenital: _____ _____
Bowel: _____ _____
Endocrine: _____ _____
Immune: _____ _____
Skeletal: _____ _____
Other: _____ _____

Therapy: ***(Attach most recent 3 months of notes)***

_____ Speech Session Frequency: _____ _____ OT Session Frequency: _____
_____ PT Sessions Frequency: _____ _____ Autism Spectrum Service Frequency: _____

Hospitalizations within last 12 months: (Attach most recent hospital discharge summary)
Date: _____ Reason: _____ Duration: _____ Comments: _____

_____

Child in school: _____ Hrs per day: _____ Days per wk: _____ IEP/IFSP: _____ N/A: _____
Nurse in attendance during school day: _____ N/A: _____ ***(Attach most recent 3 month's nursing notes)***

Skilled Nursing hours received: _____ Hrs/day: _____ N/A: _____

Attestation Statement

_____ *This child requires the skilled care that is ordinarily provided in a nursing facility or facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.*

I attest that the above information is accurate.

Physician's Signature: _____ Date: _____

Primary Caregiver Signature: _____ Date: _____

_____ *This child **does not** require the skilled care that is ordinarily provided in a nursing facility or facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.*

I attest that the above information is accurate.

Physician's Signature: _____ Date: _____

DCLH Medical Necessity/ Level of Care Statement Criteria and Requirements

NF LOC

Documents Required: DCLH Medical Necessity/ Level of Care Statement, IEP or IFSP (if in effect), physician order for nursing or rehab therapy, nursing notes (if applicable), and rehab therapy notes (if applicable).

Nursing Facility LOC is generally indicated if one of the following conditions are met:

- ✓ Skilled nursing ordered and provided 7 days per week; or
- ✓ Skilled rehab services ordered and provided at least 5 days per week.

ICF/ID LOC

Documents Required: DCLH Medical Necessity/ Level of Care Statement, Developmental Evaluation w/ score **(for ages 0-5)**, Psychological Evaluation w/ score **(for ages 6 and up)**, and IEP or IFSP (if in effect).

ICF/ID LOC is generally indicated if one of the following conditions are met:

- ✓ IQ of 70 or below; or
- ✓ Standard score of 70 or below in at least three (3) of the five (5) domains of functions (cognitive, language, motor, social-emotional, and adaptive) on a standardized developmental assessment tool or an overall standard score of 70 or below; or
- ✓ Age-equivalency composite score <50% of chronological age; or
- ✓ Standard score of 70 or below in at least three (3) domains of function on a standardized adaptive functioning test or an overall composite score of 70 or below; or
- ✓ Childhood Autism Rating Scale (CARS) score is >37, or the Gilliam Autism Rating Scale (GARS) score is 121 or greater.

Hospital LOC

Documents Required: DCLH Medical Necessity/ Level of Care Statement, physician order for nursing or rehab therapy, nursing notes (if applicable), rehab therapy notes (if applicable), and/ or hospital records (if applicable).

Hospital LOC is generally indicated if one of the following conditions are met:

- ✓ Services for the child are required 24 hours per day and required to be ordinarily furnished in an appropriately licensed institution for the care and treatment of patients with disorders other than mental illnesses.

DCLH MEDICAL NECCESSITY/LEVEL OF CARE STATEMENT

INSTRUCTIONS FOR COMPLETION

This document provides detailed instructions for completion of the DCLH Medical Necessity/ Level of Care Statement. It may be completed by physician and the primary caregiver.

Member (Applicant) Information

Enter the child's Name, DOB and SS#.

Diagnosis

Enter the child's primary, secondary, and any third diagnoses relevant to the child's condition.

Level of Care

Check the correct box for the recommended level of care, i.e., hospital, nursing facility, ICF-ID or in the alternative NA.

**NOTE: Entry of NA indicates the required institutional level of care is not met and denial of LOC is appropriate.*

Medical History

Provide narrative of member's medical history or attach documents (i.e., hospital discharge summary, etc.). List current medications name, dosage, route, and frequency.

Current Needs

Check child's current needs and provide description of skilled nursing needs.

Therapy

Therapies require a plan of care. All therapies, including school based therapies, must be ordered by a physician and accompanied by current individually signed therapy notes.

Hospitalizations

Attach most recent hospital discharge summary and document date, reason and duration.

School

Enter a check for child's appropriate school attendance and IFSP or IEP plan.

Signature

The primary care physician or physician of record must sign and date. The caregiver (parent or guardian) must also sign and date.

****Note: If a Physician recommends the child meets DCLH Level of Care, the Physician and Primary Caregiver signature and date on the Level of Care statement is required. Lack of signatures and dates will result in a Technical Denial.***

Parent Skills Checklist
Disabled Child Living at Home

This completed form is required with every application. The purpose of this checklist is to include additional information with the Disabled Child Living at Home (DCLH) application packet for the child who receives skilled treatment or therapy **personally performed** by a parent or unpaid caregiver. Qualification for the DCLH category of eligibility is not based on diagnosis or disability alone, but the child's medically documented institutional level of care needs from the most recent 12 months. Children qualifying for DCLH require more complex care at home and often parents/guardians are trained by skilled healthcare professionals to perform skills that would ordinarily be provided by a skilled healthcare professional, such as a nurse or therapists.

Member Name	Medicaid ID#	Age

DOES THE PARENT OR LEGAL GUARDIAN PROVIDE ANY TREATMENT OR SKILLED CARE NEEDS FOR THE CHILD?

◯	**NO**	I am the parent and/or legal guardian and I acknowledge that I **DO NOT** provide any treatment and/or skilled care needs for my child. **If NO, please sign here and submit with the application packet.** No further information is needed on this form.

Parent/Legal Guardian	Signature	Date

◯	**YES**	I am the parent and/or legal guardian and I acknowledge that I **DO** provide treatment and/or skilled care needs for my child. **If YES, please complete the checklist** and sign the acknowledgement at the end of the form.

Instructions: Parents should complete the form to the best of their ability to help the application review team better understand the daily healthcare needs of the child. You may request help from your child's healthcare team to complete the form.

1. Review the list of Treatment or Care Needs listed in the 1st column.
2. Place a check mark (√) for each treatment performed by a parent or unpaid caregiver in the 2nd column.
3. List the number of times the treatment(s) are done each day in the 3rd column.
4. Describe how often the treatments are performed in the home in the 4th column.
5. Describe who is performing the treatments (father, mother, other family member, etc.) in the 5th column.
6. In the last section (on page 3), describe how the training was received to perform the treatments at home.

Treatments or Care Needs	☑	# Times per Day	Describe how often the treatments are performed. For example, is it a routine task or only when needed?	List the person(s) providing the services in the home. Describe special precautions that may be needed to perform the treatment or care need.
Respiratory Care				
Tracheostomy Care				
Oxygen/CPAP/BIPAP				
Suctioning				
Ventilator				
Pulse oximetry/Apnea Monitoring				
Nebulizers				

Chest Physiotherapy/Cough Assistance				
Chest Tube				
Other; specify:				
Neurological Treatment				
Seizure medication				
Seizure precautions/interventions				
Other; specify				
Nutritional Care				
Tube feeding (Indicate whether this is continuous or a certain amount each day)				
Tube feeding or flushes used only for medications				
Other; specify:				
IV Therapy & Medication Administration				
IV flush				
Lab draws through a port or other IV line				
IV therapy (indicate medication)				
Any subcutaneous medications				
Other; specify				
Urinary treatments				
Catheterization (Indicate whether daily or as needed)				
Peritoneal Dialysis				
Other; specify				
Glucose Management				
Glucose Monitoring				
Other; specify				
Skin Care				
Skin breakdown (indicate stage, if known)				
Complex cast care				
Sterile dressing change				
Stoma care				
Other; specify				
Therapy (PT/OT/ST)				
Specify Treatment:				
Other Type of Treatment not Listed				
Specify Treatment:				

For treatments that are checked above, provide the details of the training received. For example:

- Who was the person teaching you? (doctor, nurse, respiratory therapists, etc.)
- Where did you receive the training? (in a doctor's office, by a nurse in your home, specialty hospital, etc.)
- How long did you receive the training?
- Who do you contact for questions or problems?

#1 **Treatments or Care Need - Example**
Tube feedings *Both parents were trained in the hospital after the feeding tube was placed. The nurse in the hospital showed us how to take care of the stoma so it would not get infected, how to measure the tube feeding, and how to flush the tube before and after the feeding. The nurse watched both parents perform the tube feeding for several days before discharge to make sure it was done right and to answer any questions. We were given written instructions. If there are questions or concerns now, we call our pediatrician for advice.*
#2 **Treatments or Care Need**
#3 **Treatments or Care Need**
#4 **Treatments or Care Need**

If the information cannot be entered in the space allowed, please attach additional documentation.

My signature acknowledges that the information provided on this checklist is true and accurate. As the parent and/or legal guardian of the beneficiary receiving services, my signature confirms that I have received training and I personally provide the services checked on this form.

Name of Parent or Legal Guardian	Signature	Date

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Xxxxxx Regional Office
0000 Xxxxxxx Xx
Xxxxxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxxxxx X. Xxxxxx
0000 Xxxxxxx Xx
Xxxxxxx, MS 00000

Client Name: Xxxxxxxxx X. Xxxxxx
Medicaid ID: 000-00-0000

REQUEST FOR INFORMATION

Dear Xxxxxxxxx X. Xxxxx:

The information listed below is required to process your request for Health Benefits or to determine your continued eligibility for Health Benefits.

Please provide the information listed below before MM/DD/YYYY:

1. Provide Social Security Numbers for each applicant or proof that an application for a Social Security Number has been filed. Non-applicants and aliens applying for Emergency Medicaid are not required to provide Social Security Numbers.

If you have questions concerning the information being requested, you may contact your regional Division of Medicaid office at **(000) 000-0000.**

MESSAGE FROM YOUR CASE WORKER

Khylie's Social Security number is needed to process the application.

Case Worker: **Xxxxxx X. Xxxxxx** Date: **MM/DD/YYYY**
Phone: **(000) 000-0000**
Fax: **(000) 000-0000**

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Xxxxxxxxx Regional Office
0000 Xxxxxx Xx
Xxxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxxx Xxxxxxxx
0000 Xxxxxxx Xx
Xxxxxx, MS 00000-0000

Client Name: Xxxxxx X. Xxxxxxx
Medicaid ID: 000-00-0000

SECOND REQUEST FOR INFORMATION

Dear Xxxxxx Xxxxxxx:

On MM/DD/YYYY, you were mailed a request for the following information:

Either bring or mail in the information listed below before MM/DD/YYYY:

1. Provide the last three (Xxxxx, Xxxxx, and Xxxxx) months bank statements on all accounts you or your spouse own or accounts that have your name listed as one of the owners or that your name is on.
2. Send an explanation of any deposits to your bank account other than any Social Security received.

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 this information by MM/DD/YYYY, appropriate action will be taken to close the client's Medicaid case.

MESSAGE FROM YOUR CASE WORKER

Please contact your case worker as soon as possible.

Case Worker: **Xxxxxx X. Xxxxx** Date: **MM/DD/YYYY**
Phone: **(000) 000-0000**
Fax: **(000) 000-0000**

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Xxxxxxxx Regional Office
0000 Xxxxxxxxx Xx
Xxxxxxxx, MS 00000.0000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxx Xxxxx
0000 Xxxxxx Xx
Xxxxxxx, MS 00000-0000

MM/DD/YYYY

NOTICE OF PENDING MEDICARE SAVINGS PROGRAM APPLICATION

Dear Xxxxx Xxxxxx**,**

When you applied for the Extra Help with Medicare Prescription Drug Plan costs, you also started your application for the Medicare Savings Programs.

The Division of Medicaid has received your application from the Social Security Administration and it is now being processed. The Division of Medicaid is allowed 45 days from the date of this notice to complete your application. Once your application has been processed, the Division of Medicaid will tell you in writing whether or not you are eligible for a Medicare Savings Program.

The Medicare Savings Programs are different programs based on Medicare entitlement and income. There is no asset test for these groups, but income you receive from your assets is counted.

> Individuals and couples with income at or below the federal poverty level can qualify for Medicaid to pay Medicare premiums, deductibles, and co-insurance charges. Coverage for this benefit will not begin until the month following the month of approval.
>
> Individuals and couples with income at or below 135% can qualify for Medicaid to pay the monthly Medicare Part B premiums. This is the only benefit available.

If you have any questions, please visit or call the office listed below:

Xxxxxxxx Regional Office
0000 Xxxxxxxxx Xx
Xxxxxxxx, MS 00000-0000
Phone: **(000) 000-0000**

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Punjabi | ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-800-421-2408 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

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Xxxxxx Regional Office
0000 Xxxxxe Xx.
Xxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxxx Social Security Administration
0000 Xxxxxxx Xx.
Xxxxxx, MS 00000

Client Name: **Xxxxx X. Xxxxxxx**
Medicaid ID: **000-00-0000**
Social Security Number: **000-00-0000**

REPORT TO DISTRICT OR BRANCH SOCIAL SECURITY OFFICE

The above named person is being referred to you as a possible claimant for SSI benefits. Should this person be determined to be eligible for benefits, please report to us the beginning month of eligibility. The client's mailing address is:

0000 Xxxxxxx Xx
Xxxxxxxx, MS 00000-0000

Remarks: **Xxxxxxxxxx xxxxxxxxx xxx xxxxxxxxxxx.**

Case Worker: **Xxxxx X. Xxxxx**

Date: **MM/DD/YYYY**

Xxxxxxx Regional Office
0000 Xxxxxxx
Xxxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxxxx Social Security Administration
0000 Xxxxxxxx
Xxxxxxx, MS 00000

Client Name: **Xxxxxx Xxxxxx**
Medicaid ID: **000-00-0000**
Social Security Number: **000-00-0000**

REPORT TO DISTRICT OR BRANCH SOCIAL SECURITY OFFICE

The Division of Medicaid is reporting that SSI individual **8ØØØØØ 8ØØØØØ** has entered a Title XIX institution, **888888888 8888888 888 88888888888888,** as a patient on **MM/DD/YYYY.**

Case Worker: **Xxxxxx X. Xxxxxxx**

Date: **MM/DD/YYYY**

Xxxxxxxx Regional Office
0000 Xxxxxx Xx
Xxxxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxxxxx Social Security Administration
0000 Xxxxxxxx Xx
Xxxxxxxx, MS 00000

Client Name: **Xxxxxx X. Xxxxxx**
Medicaid ID: **000-00-0000**
Social Security Number: **000-00-0000**

REPORT TO DISTRICT OR BRANCH SOCIAL SECURITY OFFICE

The Division of Medicaid is reporting that SSI individual **Xxxxxx X. Xxxxxx** was discharged from a Title XIX institution on **MM/DD/YYYY.**

Client's Mailing Address is: **0000 Xxxxxxx Xx**
Xxxxxxx, MS 00000-0000

Remarks: **Xxxxxxxxxxxx xxxxxxxx xxxxx**

Case Worker: **Xxxxxxxx X. Xxxxx**

Date: **MM/DD/YYYY**

Xxxxxx Regional Office
0000 Xxxxxxx Xx
Xxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxxx Xxxxxxx
0000 Xxxxxxx Xx
Xxxxxx, MS 00000-0000

Client Name: **Xxxxx X. Xxxxx**
Medicaid ID: **000-00-0000**

NOTICE OF TRANSFER OF ASSETS

Anyone applying for or receiving long term care services in a nursing home or Home and Community Based Services (HCBS)Waiver is prohibited from transferring assets at any time during the 60-month period (5 years) before applying for Medicaid and during the time Medicaid is received. If assets are transferred, a period of ineligibility shall be charged which is equal to the number of months required to deplete the total uncompensated value based on the total value of all transferred asset(s) divided by the average cost of monthly nursing home care to a private pay patient as determined by the Division of Medicaid. The period of ineligibility begins when the client asks for coverage or is otherwise eligible for nursing home and Medicaid

Nursing home recipients under a transfer penalty will receive all Medicaid services except the per diem payment to the nursing home, ICF/IID or hospital swing bed for room and board.

Eligibility cannot be established for Home and Community Based (HCBS) Waiver services during the transfer penalty period

This transfer of assets provision applies to assets transferred on or after February 8, 2006, as specified in the Deficit Reduction Act of 2005. Assets can be returned in full and the transfer penalty will be erased Returned assets will be evaluated according to ongoing resource rules.

Listed below is specific information about assets transferred by the Medicaid client named at the top of this notice:

Resource Type	Amount	Date
Real Property	**$$$$,$$$.$$**	**MM/DD/YYYY**

Uncompensated Value: **$$$, $$$.$$**

Period of Ineligibility for **HCBS Waiver Services:**

Beginning: **MM/DD/YYYY**

Ending: **MM/DD/YYYY**

Beginning and end dates are subject to change. You will be issued a revised DOM-322 if any dates or other information changes.

If you wish to rebut the transfer charge, you must give us evidence that the resource(s) was disposed of at current market value or for other valuable consideration or that the resource(s) was transferred exclusively for a purpose other than qualifying for Medicaid.

You have 10 days from the date you receive this notice to submit such evidence before final action is taken on this case.

An undue hardship waiver may be requested by a client or the client's authorized representative. If the client is in a nursing home, ICF/IID or hospital swing bed, the facility may apply for a hardship waiver on behalf of the client if the facility has the client's consent or their authorized representative's consent. If you claim undue hardship, the Division of Medicaid will review the circumstances of the transfer on a case by case basis using established policy located in the Eligibility Policy and Procedures Manual. The hardship waiver is not related to a hardship for the facility, but rather a hardship for the client..

Case Worker: **Xxxxxxxx X. Xxxxx**

Date: **MM/DD/YYYY**

Notice of Non-Discrimination

The Mississippi Division of Medicaid complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Mississippi Division of Medicaid:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Mississippi Division of Medicaid has discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 550 High Street Suite 1000, Jackson, MS 39201, toll-free: 1-800-421-2408, fax: 601-359-6294, email: civilrights@medicaid.ms.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, toll-free: 800-368-1019, TDD: 800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak another language, assistance services are available to you free of charge. Call 1-800-421-2408 (TTY: 711).

Spanish | ATENCIÓN: si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia. Llame al 1-800-421-2408 (TTY: 711).

Vietnamese | CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-421-2408 (TTY: 711).

Chinese | 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-800-421-2408（TTY：711）

French | ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-421-2408 (ATS : 711).

Arabic | ملحوظة: إذا كنت تتحدث باللغة العربية، فسيتم توفير خدمات المساعدة بدون رسوم. اتصل بالرقم 1-800-421-2408 (رقم هاتف الصم والبكم: ٧١١).

Choctaw | Ho hakloh! Annopa ila ish anópolih ihokma, chiyápila hinakat oklah máyah. Iyallít ikshoh. Ipayah 1-800-421-2408 (TTY: 711).

Tagalog | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-421-2408 (TTY: 711).

German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-421-2408 (TTY: 711).

Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-421-2408(TTY: 711) 번으로 전화해 주십시오.

Gujarati | **સુચના: જો તમે ગુજરાતી બોલતા હો, તો ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-800-421-2408 (TTY: 711) પર ફોન કરો.**

Japanese | 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-421-2408（TTY: 711）まで、お電話にてご連絡ください。

Russian | ВНИМАНИЕ! Если вы говорите на русском языке, вам могут быть бесплатно предоставлены услуги перевода. Звоните по телефону 1-800-421-2408 (телетайп: 711).

Punjabi | ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-800-421-2408 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

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Hindi | ध्यान दें: यदि आप कोई और भाषा बोलते हैं, तो सहायता सेवाएं आप के लिए नि: शुल्क उपलब्ध हैं। 1-800-421-2408 (TTY: 711) पर कॉल करें।

Xxxxxxx Regional Office
0000 Xxxxx Xx
Xxxxxxx, MS 00000

MISSISSIPPI DIVISION OF
MEDICAID

Xxxxxx Xxxxxx
0000 Xxxxxxx Xx
Xxxxxx, MS 00000-0000

Client Name: **Xxxxxx X. Xxxxx**
Medicaid ID: **0000-00-0000**

NOTICE OF DECISION ON LOCAL HEARING

This is to notify you of the decision reached as a result of the local hearing held on MM/DD/YYYY. The decision is as follows:

The previous decision rendered by the Holly Springs Regional Medicaid Office has been reversed. Client is approved for Medicaid eff. MM/DD/YYYY.

If you disagree with this decision and wish to request a State hearing, we must receive your request within 15 days from the date of mailing shown below. In order to request a State hearing, you may complete the bottom portion of this form and mail it to the Regional Office at the address shown above. If we do not hear from you by MM/DD/YYYY, we will know that you understand the reason for this decision on your hearing.

Local Hearing Officer: **Xxxxxxx Xxxxx** Date: MM/DD/YYYY

COMPLETE THIS SECTION IF YOU WISH TO REQUEST A STATE HEARING

I wish to request a State hearing because I disagree with the decision reached on my local hearing.

Signature of Client or Representative _____ Date _____

Enclosures: Hearing Pamphlet
Notice of Non-Discrimination Flyer

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MISSISSIPPI DIVISION OF MEDICAID

Eligibility Hearings

What are my rights before, during, and after a hearing?

You, or the person you choose to represent you, have the following rights:

- You have the right to read everything in your case record which is kept on file at the Medicaid Regional Office. The case record has all the documents used by the Division of Medicaid to make an eligibility decision. You may look at this file anytime during the hearing process.
- You have the right to have a lawyer help you during the hearing.
- You have the right to have witnesses testify for you.
- You have the right to present evidence which may help your case at the hearing and discuss the facts about your situation.
- You have the right to explain your case without any interference.
- You have the right to question or refute any testimony or evidence and to question any witness.
- You have the right to an expedited hearing if there is a medically urgent treatment or procedure scheduled or needed and you are uninsured.

The Division of Medicaid complies with all state and federal policies which prohibit discrimination on the basis of race, age, sex, national origin, handicap or disability- as defined through the Americans with Disabilities Act of 1990.

What is an Eligibility Hearing?

An eligibility hearing is a legal process that you may ask for if you do not agree with a decision made by the Division of Medicaid about your eligibility.

How do I ask for a hearing?

If you disagree with the action taken by the Division of Medicaid for any of the individuals shown on your notice, you may request a local and/or state hearing, as described below. If you have questions or need assistance, call the Medicaid Regional Office at the number provided below or the Office of Eligibility at 1-800-421-2408.

Hearing requests can be made in one of the following ways: in person, by mail, by telephone, or through other commonly available electronic means to the Medicaid Regional Office shown on your notice.

You must request a local or state hearing before 30 days from the date of mailing on your notice. However, this deadline may be extended if you can show good cause for not filing your request within 30 days. If any person named in this notice already has Medicaid or CHIP, that person can keep their coverage if you ask for a hearing within 15 days of the date of mailing on your notice. However, if the Division of Medicaid's action is upheld by the hearing decision, the agency has the right to initiate action for recovering benefits received during the hearing process.

Local and/or state hearings are held by telephone unless, at the hearing officer's discretion, an in-person hearing is deemed necessary.

What is the difference between local hearings and state hearings?

A **local hearing** is an informal review of your case, usually conducted by a supervisor in the Medicaid Regional Office. The hearing will not be held by a supervisor that handled the action taken on your case. At the local hearing you will be able to present additional or new information that could affect your case, ask questions about actions taken on your case and have the eligibility rules explained to you. Once the local hearing has been held, the supervisor who

heard the case will make a decision based on the facts of the case and notify you in writing of the decision. If you do not agree with the local hearing decision, you can then request a state hearing.

Exception: If the issue involves a disability or blindness denial or termination or a level of care denial for a disabled child living at home, a state hearing must be held.

A **state hearing** is much like a local hearing except that your case will be reviewed by a State Hearing Officer who has not been involved with your case before the hearing and the hearing will be recorded. After the hearing has been held, the Director of the Division of Medicaid will issue a decision based on the facts of the case and the recommendations of the State Hearing Officer. The state hearing decision is final within the Division of Medicaid. You cannot ask for another hearing on the same issue; however, you can seek judicial review in a court of appropriate jurisdiction.

How will I know when my hearing has been scheduled?

You will get a letter in the mail telling you the time and date of the hearing. If you are not able to talk on that date, you should call the Medicaid Regional Office (if you requested a local hearing) or the State Hearing Officer at the number on your letter as soon as possible to set another date.

The Division of Medicaid has 90 days to make a hearing decision.

Expedited Hearing

You may request an expedited (faster) hearing if you have an immediate need for a health service such as a medical procedure or treatment that has been scheduled or needs to be scheduled and you are uninsured. You can request an expedited hearing by contacting your local regional office in person, by mail, by telephone or through other commonly available electronic means. We will let you know if your request is granted or denied. If your expedited hearing request is granted, the timeframe for a decision is 7 working days. If your request for an expedited hearing is denied, your hearing request will follow the standard hearing timeframe of ninety (90) days.

Regional Offices

If you have questions about eligibility or how to apply for Medicaid, call your nearest Medicaid Regional Office in:

Brandon	(601) 825-0477
Brookhaven	(601) 835-2020
Canton	(601) 978-2399
Clarksdale	(662) 627-1493
Cleveland	(662) 843-7753
Columbia	(601) 731-2271
Columbus	(662) 329-2190
Corinth	(662) 286-8091
Greenville	(662) 332-9370
Greenwood	(662) 455-1053
Grenada	(662) 226-4406
Gulfport	(228) 863-3328
Hattiesburg	(601) 264-5386
Holly Springs	(662) 252-3439
Jackson	(601) 978- 2399
Kosciusko	(662) 289-4477
Laurel	(601) 425-3175
McComb	(601) 249-2071
Meridian	(601) 483-9944
Natchez	(601) 445-4971
New Albany	(662) 534-0441
Newton	(601) 635- 5205
Pascagoula	(228) 762-9591
Philadelphia	(601) 656-3131
Picayune	(601) 798-0831
Senatobia	(662) 562-0147
Starkville	(662) 323-3688
Tupelo	(662) 844-5304
Vicksburg	(601) 638-6137
Yazoo City	(662) 746-2309

Office of the Governor
Division of Medicaid
550 High St, Suite 1000
Jackson, Mississippi 39201

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  - Information written in other languages

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, toll-free: 800-368-1019, TDD: 800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-421-2408(TTY: 711) 번으로 전화해 주십시오.

Gujarati | **સુચના: જો તમે ગુજરાતી બોલતા હો, તો ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-800-421-2408 (TTY: 711) પર ફોન કરો.**

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Punjabi | ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-800-421-2408 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Italian | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-421-2408 (TTY: 711).

Hindi | ध्यान दें: यदि आप कोई और भाषा बोलते हैं, तो सहायता सेवाएं आप के लिए नि: शुल्क उपलब्ध हैं। 1-800-421-2408 (TTY: 711) पर कॉल करें।

00/00/0000

Xxxxx Regional Office
0000 Xxxxxx Xxxx
Xxxxxx, MS 00000

MISSISSIPPI DIVISION OF MEDICAID

Xxxxx X Xxxxx
0000 Xxxx 000
Xxxxxx, MS 00000

Head of Household: **Xxxxx X Xxxxx**
Case Number: **000000000**
Case Worker: **Xxxx X. Xxxxxxxx**
Phone: **(000) 000-0000**
Fax: **(000) 000-0000**

Renewal Notice

FOR MISSISSIPPI HEALTH BENEFITS

This is your family's yearly renewal notice for Medicaid and/or CHIP eligibility. Please review the information in this notice carefully. Tell us what has changed and provide new or corrected information in the space provided. This information, **with proof of your income**, is due by **00/00/0000**.

You can renew in one of the following ways:

- Mail or fax your completed renewal form to your local Medicaid office above,
- In-person assistance with renewal is available at your local Medicaid regional office,
- Telephone assistance with renewal is available through your local Medicaid office or the Office of Eligibility at 800-421-2408.

You do not have to contact your worker unless you need assistance with answering the questions.

A response is required even if you have no changes. Proof of your income is also required. If information is not provided by the due date, action must be taken to close your case.

Section 1 – Your Information as Head of Household (or primary contact for the household):

What Medicaid Has:	Enter any changes needed:
Xxxxx X Xxxxxx	
0000 Xxxx 000	
Xxxxxx, MS 00000	
Telephone or Contact Number: **(000) 000-0000**	
Preferred Language: **Xxxxxx**	

Section 2 – Your Representative (this is not a contact person). The person named below is the person you selected to act in your behalf to sign your renewal forms and receive letters and notices about Medicaid, CHIP or health coverage through the federal marketplace. **You can change your designation or you may add a new person to act for you. If you add someone new to act for you, you must sign in this section. In addition, you or the person you designate here must also sign the Signature section on the last page of this form.**

What Medicaid Has:	Make any needed changes or add someone new
Xxxx	

Signature of Head of Household **Date**

Section 3 – Household Members: These are the people that we show living in your household based on what you told us last year.

Person	Household Members Known to Medicaid	Relationship to You	Household Members Currently Eligible	Enter Changes
1	**Xxxxxx X Xxxxxx**	**Xxxx**	**Xxxxxxxx**	
2	**Xxxxxx X Xxxxxx**	**Xxxx**	**Xxxxxxxx**	
3	**Xxxxxx X Xxxxxx**	**Xxxx**	**Xxxxxxxx**	
4	**Xxxxxx X Xxxxxx**	**Xxxx**	**Xxxxxxxx**	

Note: If any household member shown above is a newborn added to your case during this past review period, you need to give us the infant's Social Security Number as part of this review so that we can continue the child's eligibility:

Name of Infant _____ SSN _____

Name of Infant _____ SSN _____

If more than 2 infants added to your case, enter name(s) and SSN(s) below:

Section 4 – Information on Known Household Members – please review the information we have on each person and enter any changes that are needed:

Person 1 - This is the person shown as Head of Household	
What Medicaid Has:	Make any needed corrections:
Name: **Ashlee M Abbott**	
Date of Birth: **08/08/1989**	
Sex: **F**	
Race: **White**	
Tax Filing Status: **Married Filing Jointly**	
Tax Dependent(s) Claimed by this person: **Abigail M Abbott**	
Tax Filer Claiming this person as a Dependent:	
Relationship of Tax Filer Claiming this person as a Dependent:	

Person 2- What Medicaid Has:	Make any needed corrections:
Name: **Xxxxxx X Xxxxxxx**	
Date of Birth: **00/00/0000**	
Sex: **X**	
Race: **Xxxxx**	
Tax Filing Status: **Xxxxxxx Xxxxxx Xxxxxx**	
Tax Dependent(s) Claimed by this person: **Xxxx X Xxxxxx**	
Tax Filer Claiming this person as a Dependent:	
Relationship of Tax Filer Claiming this person as a Dependent:	

Person 3- What Medicaid Has:	Make any needed corrections:
Name: **Xxxxxxx X Xxxxxx**	
Date of Birth: **00/00/0000**	
Sex: X	
Race: **Xxxxxxxxxxxx Xxxx**	
Tax Filing Status:	
Tax Dependent(s) Claimed by this person:	
Tax Filer Claiming this person as a Dependent: **Xxxxxx X Xxxxxxx**	
Relationship of Tax Filer Claiming this person as a Dependent: **Xxxxxx**	

Person 4- What Medicaid Has:	Make any needed corrections:
Name: **Xxxxxxx X Xxxxxx**	
Date of Birth: **00/00/0000**	
Sex: **X**	
Race: **Xxxxxxxxxx Xxxx**	
Tax Filing Status:	
Tax Dependent(s) Claimed by this person:	
Tax Filer Claiming this person as a Dependent: **Xxxxxx X Xxxxxxxx**	
Relationship of Tax Filer Claiming this person as a Dependent: **Xxxxxx**	

Person 5- What Medicaid Has:	Make any needed corrections:
Name: **Xxxx X Xxxxxxx**	
Date of Birth: **00/00/0000**	
Sex: **X**	
Race: **Xxxxx**	
Tax Filing Status:	
Tax Dependent(s) Claimed by this person:	
Tax Filer Claiming this person as a Dependent: **Xxxxxx X Xxxxxx**	
Relationship of Tax Filer Claiming this person as a Dependent: **Xxxxxx**	

Section 5 – Household Members or Tax Dependents Not Shown Above – If there are any household members **who are not shown above,** list them here.

Name	Date of Birth	Sex	Relationship to You	Social Security Number*	Race	Will you claim this person as a tax dependent? Yes/No

Entering "race" is optional, but please use the following: White, Black, American Indian, Alaskan Native, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, Mexican, Chicano/a, Puerto Rican, Cuban or Other (specify).

*We need Social Security Numbers (SSN's) for everyone applying. You are not required to give us SSN's of anyone not applying but it will speed up the renewal process if you do provide SSN's for everyone. We use SSN's to check income and other information to see who is eligible for help with health coverage. If you need help getting an SSN, contact Social Security at 1-800-772-1213 or visit socialsecurity.gov.

Do any of the household members you listed above file taxes? ☐ Yes ☐ No If yes, complete the following:

Name of Tax Filer	Filing Status(Individual, Head of Household, Married Filing Jointly or Separately)	Name of Spouse	Number of Dependents Claimed	Names of Dependents Claimed

Will any of the household members listed above be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No If yes, complete the following:

Name of Tax Dependent	Name of Tax Filer	How is Dependent Related to Tax Filer?

If you plan to claim someone as a tax dependent who **does not** live with you, list him/her here.

Name	Age	Sex	Relationship to You	Social Security Number*	Race

*We need Social Security Numbers (SSN's) for everyone applying. You are not required to give us SSN's of anyone not applying but it will speed up the renewal process if you do provide SSN's for everyone. We use SSN's to check income and other information to see who is eligible for help with health coverage. If you need help getting an SSN, contact Social Security at 1-800-772-1213 or visit socialsecurity.gov.

Do you want to apply for any household member listed above, who is not currently eligible for health coverage? □ Yes □ No If yes, name the individual(s) applying and answer Yes or No about US citizenship. For each applicant who is not a US citizen or US National, provide information requested about immigration status. **NOTE:** Also be sure you provide information about each person named as applying here in all of Section 5 above and in all remaining Sections below.

Name	Is person a US Citizen or US National?	For each person who is not a US citizen or US National, enter (1) immigration status, (2) immigration document and (3) ID number below:	Has this person lived in US since 1996?	Is this person or his/her spouse or parent a veteran or active duty military?

For each person you named who wants to apply, we need the following information:

Is anyone applying pregnant? □ Yes □ No If yes, provide the following:

Name(s)	Expected Date of Delivery	How Many Babies Expected?

Is anyone who is applying the primary caregiver of at least one child under the age of 18 living in the home □ Yes □ No If yes, provide the following:

Name(s) of Primary Caregiver _____

Name of Child or Children _____

Name of Child or Children with a Parent Living Outside the Home _____

If a parent lives outside the home, the primary caregiver of the child will be asked to cooperate with child support services to collect medical support from the absent parent(s) unless child support services determines there is good cause not to cooperate.

Was anyone applying in foster care at age 18 or older? □ Yes □ No
If yes, in what state? _____

Section 6 – Current Job & Income Information for All Household Members – we have entered the income known to us. Make any changes needed to the income shown. Report any/all income for all household members listed in this form. Be sure to include the income of tax dependents not living in the household, if this applies to you.

Earned Income: These are wages received by you or other household members.

Person Employed	Amount of Wages Before Deductions (Gross Earnings)	How Often Received	Enter any changes and enter any earnings not shown. **You must send in proof of wages for each person.**
Xxxxxx X Xxxxxx	**$00,000.00**	**Xxxxxxxxx**	

Self-Employment Income: These are net earnings from self-employment received by you or other household members. You must send in the last available federal tax return for each self-employed person to update our information.

Person Self-Employed	Amount of Net Earnings	Enter any changes and enter any self-employment not shown. **You must send in proof of net earnings for each person self-employed.**

Unearned Income: This is other income received by you and all other household members. Unearned income is from any source that is not from employment. Income from Social Security, Railroad Retirement, VA, SSI, state or federal or municipal retirement, private pensions, trust income, rental income, income from interest or dividends, child support and/or alimony, cash contributions or any "other" type of income received is unearned income.

Person with Income	Source or Type	Amount/How Often	Enter any changes – or add any new source of income for each household member. **You must send in proof of income for each source, other than Social Security, SSI or State Retirement (PERS), Child Support, VA or Workers' Compensation.**

Deductions from Income: Certain deductions reported on a federal tax return are allowed to be deducted from reported income (unless already deducted from the income amount shown above). If any household member pays alimony, student loan interest or has other allowable deductions, tell us:

Name of Household Member	Type of Deduction	Amount Paid	How Often?	Enter any changes/additions

Income Changes – If any household member's income changes from month to month or if there is a known change in income in future months for any household member, tell us:

Name of Household Member	Type of Income	Explain Change in Income

No Income Reported – <u>If you are not working and there is no regular source of income reported above,</u> tell us here how you and your household are making ends meet on a month to month basis :

Section 7 – Health Insurance: We show the following household members have health insurance other than Medicaid or CHIP. Health coverage includes Medicare, state or federal health insurance, private insurance, or any health coverage. Health coverage for any/all eligible or applying household members needs to be reported in this section. NOTE: Family Planning recipients reporting health insurance must also indicate whether the insurance covers family planning services.

What Medicaid Has:	Name/Type of Plan	Make any needed changes or add any new health coverage.
Xxxxxx X Xxxxxx	**Xx Xxxxxxxx Xxxxxxx**	
Xxxxxx X Xxxxxx	**Xx Xxxxxxxx Xxxxxxx**	
Xxxxxx X Xxxxxx	**Xx Xxxxxxxx Xxxxxxx**	
Xxxxxx X Xxxxxx	**Xx Xxxxxxxx Xxxxxxx**	

Section 8 – Family Planning: The questions in this section must be answered for the individuals whose names are listed below.

What Medicaid Has:	If female, are you pregnant?	Have you had a hysterectomy, tubal ligation (female) or vasectomy (male)?
Xxxxxx X Xxxxxx		

Deductions from Income: Certain deductions reported on a federal tax return are allowed to be deducted from reported income (unless already deducted from the income amount shown above). If any household member pays alimony, student loan interest or has other allowable deductions, tell us:

Income Changes – If any household member's income changes from month to month or if there is a known change in income in future months for any household member, tell us:

Name of Household Member	Type of Income	Explain Change in Income

No Income Reported – If you are not working and there is no regular source of income reported above, tell us here how you and your household are making ends meet on a month to month basis :

Section 7 – Health Insurance: We show the following household members have health insurance other than Medicaid or CHIP. Health coverage includes Medicare, state or federal health insurance, private insurance, or any health coverage. Health coverage for any/all eligible or applying household members needs to be reported in this section. NOTE: Family Planning recipients reporting health insurance must also indicate whether the insurance covers family planning services.

Section 8 – Family Planning: The questions in this section must be answered for the individuals whose names are listed below.

What Medicaid Has:	If female, are you pregnant?	Have you had a hysterectomy, tubal ligation (female) or vasectomy (male)?

Section 9 – If there are any other changes that you need to report other than what is shown in this notice, please use this space to report any changes or new information:

_____

_____

Your Rights & Responsibilities

☐ I am signing this renewal form under penalty of perjury. This means I have provided true answers to all of the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
☐ I know that I must tell the Division of Medicaid if anything changes and if different from what I wrote on this form. I can call 1-800-421-2408 or visit www.medicaid.ms.gov to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
☐ I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex (gender), age, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
☐ If I think the Division of Medicaid has made a mistake, I can appeal its decision and ask for a fair hearing. To find out how to file an appeal, contact the Division of Medicaid at 1-800-421-2408 or visit www.medicaid.ms.gov. Someone from the Division of Medicaid will explain the appeal process.
☐ I understand that if I do not qualify for Medicaid (or CHIP for children under age 19), the Division of Medicaid may send my information to the federal marketplace to see if I qualify for health coverage. The Division of Medicaid will check my answers using information from data sources such as the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security, and others. If the information does not match with my answers on this form, the Division of Medicaid may ask me to send in more information.
☐ I understand that when I send in this form, it means I have permission from everyone whose information is on this form to submit their information to the Division of Medicaid and receive any communications about their eligibility and enrollment.
☐ I understand that the Division of Medicaid is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (P.L. 111-152) and the Social Security Act.
☐ I understand if I receive family planning services under the Family Planning Waiver, ,I authorize my family planning provider to release information to Medicaid relating to my examination and treatment for family planning.

Your Signature – You or the representative you named in Section 2 must sign this application:

_____ _____

Signature of Head of Household or Representative **Date**

Does the Head of Household want to register to vote: ☐ Yes ☐ No
If yes, complete the attached Voter Registration form and return it with this renewal form.

Notice of Non-Discrimination

The Mississippi Division of Medicaid complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Mississippi Division of Medicaid:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
    - You may also visit www.mississippirelay.com for additional services.

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Civil Rights Coordinator at 1-800-421-2408 or by email at civilrights@medicaid.ms.gov.

If you believe that the Mississippi Division of Medicaid has discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, 550 High Street Suite 1000, Jackson, MS 39201, toll-free: 1-800-421-2408, fax: 601-359-6294, email: civilrights@medicaid.ms.gov.You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, toll-free: 800-368-1019, TDD: 800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak another language, assistance services are available to you free of charge. Call 1-800-421-2408 (TTY: 711).

Spanish | ATENCIÓN: si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia. Llame al 1-800-421-2408 (TTY: 711).

Vietnamese | CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-421-2408 (TTY: 711).

Chinese | 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-800-421-2408（TTY：711）

French | ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-421-2408 (ATS : 711).

Arabic | ملحوظة: إذا كنت تنطق باللغة العربية، فسيتم توفير خدمات المساعدة بدون رسوم. اتصل بالرقم 1-800-421-2408. (رقم هاتف الصم والبكم: ٧١١)

Choctaw | Ho hąkloh! Annọpa i̲la ish anópolih ihokma̲, chiyápila hi̲nakat oklah máyah. Iyallít ikshoh. I̲pa̲yah 1-800-421-2408 (TTY: 711).

Tagalog | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-421-2408 (TTY: 711).

German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-421-2408 (TTY: 711).

Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-421-2408(TTY: 711) 번으로 전화해 주십시오.

Gujarati | સુચના: જો તમે ગુજરાતી બોલતા હો, તો ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-800-421-2408 (TTY: 711) પર ફોન કરો.

Japanese | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-421-2408（TTY: 711）まで、お電話にてご連絡ください。

Russian | ВНИМАНИЕ! Если вы говорите на русском языке, вам могут быть бесплатно предоставлены услуги перевода. Звоните по телефону 1-800-421-2408 (телетайп: 711).

Punjabi | ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। 1-800-421-2408 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Italian | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-421-2408 (TTY: 711).

Hindi | ध्यान दें: यदि आप कोई और भाषा बोलते हैं, तो सहायता सेवाएं आप के लिए नि: शुल्क उपलब्ध हैं। 1-800-421-2408 (TTY: 711) पर कॉल करें।

MISSISSIPPI MAIL-IN VOTER REGISTRATION APPLICATION

Agency Code:

- You can use this form to: register to vote in Mississippi or change your name and/or address.
- If you are registering for the first time in Mississippi and DO NOT have a Mississippi driver's license or social security number, you must send with this application a copy of a current and valid photo ID or a copy of a current utility bill, bank statement, government check, paycheck or other government document that shows your name and address in this county.
- An application for voter registration must be postmarked or hand delivered to the Circuit Clerk's Office located in the county of your voting residence no later than 30 days before an election.
- You may not register to vote if you have been convicted in a Mississippi state court of any of the following crimes: voter fraud, murder, rape, bribery, theft, arson, obtaining money or goods under false pretense, perjury, forgery, embezzlement, bigamy, armed robbery, extortion, felony bad check, felony shoplifting, larceny, receiving stolen property, robbery, timber larceny, unlawful taking of a motor vehicle, statutory rape, carjacking or larceny under lease or rental agreement.
- If you live in an area without house numbers or street names, please include a drawing of your location to enable us to identify your appropriate voting precinct.
- Photo ID Required to Vote: You will be required to present an acceptable form of photo identification when you vote at your polling place on Election Day or by absentee ballot in your Circuit Clerk's Office, unless exempted by law. For more information, go to www.MSVoterID.ms.gov or call (844) 678-6837.

Check One: □ **New Registration** □ **Change of Information**	**Are you a citizen of the United States of America?** **Yes** □ **No** □ **Will you be 18 years of age on or before Election Day?** **Yes** □ **No** □ ***NOTE: If you checked 'No' in response to either of these questions, DO NOT complete this form.*** **Would you like to serve as an Election Day poll worker?** **Yes** □ **No** □				
Name	Last Name	Maiden Name	First Name	Middle Name	Suffix
Physical Home Address (Where you live)	Number and Street/Road/Dorm/Apt #				
	City	County	State: MS	Zip	
Mailing Address (If different from above)	Street or Post Office Box				
	City	County	State:	Zip	
Date of Birth	Month / Day	Year	**MS Driver's License Number or Last 4 Digits of your Social Security Number**	_____ or ___ ___ ___ ___	
Phone #	Cell ( )	Work ( )			
Email					
Previous Registration	Name	Address			
	City	County	State:	Zip	

VOTER DECLARATION- Read and Sign

I swear/affirm, under penalty of perjury, that:

- I am a U.S. citizen.
- I will be 18 years of age on or before the next general Election Day.
- I am a resident of Mississippi, this county and this city for at least 30 days.
- I have not been adjudicated as mentally incompetent.
- I have never been convicted of voter fraud or any other disenfranchising crime OR, if convicted, I have had my voting rights restored as required by law.
- The address listed above is my legal place of residence.

WARNING: Giving false information to register to vote is a felony punishable by a fine of not more than $5,000 or imprisonment for not more than 5 years, or both. Miss. Code Ann. § 23-15-17.

X _____ **Date:** _____
Signature (or mark) of applicant

X _____ **Date:** _____
If applicant is unable to sign, the person who assisted the applicant

_____
Address

FROM: _____

_____

_____

Postage Required
Post Office will not deliver without proper postage.

TO: County Circuit Clerk

_____

_____

_____

ADAMS COUNTY
115 S. Wall Street
Natchez, MS 39120

ALCORN COUNTY
P.O. Box 430
Corinth, MS 38835

AMITE COUNTY
P.O. Box 312
Liberty, MS 39645

ATTALA COUNTY
100 Courthouse, Ste. 1
Kosciusko, MS 39090

BENTON COUNTY
P.O. Box 262
Ashland, MS 38603

BOLIVAR COUNTY
P.O. Box 670
Cleveland, MS 38732

CALHOUN COUNTY
P.O. Box 25
Pittsboro, MS 38951

CARROLL COUNTY
P.O. Box 6
Vaiden, MS 39176

CHICKASAW COUNTY
1 Pinson Square, Rm. 2
Houston, MS 38851

CHOCTAW COUNTY
P.O. Box 34
Ackerman, MS 39735

CLAIBORNE COUNTY
P.O. Box 549
Port Gibson, MS 39150

CLARKE COUNTY
P.O. Box 216
Quitman, MS 39355

CLAY COUNTY
P.O. Box 364
West Point, MS 39773

COAHOMA COUNTY
P.O. Drawer 849
Clarksdale, MS 38614

COPIAH COUNTY
P.O. Box 467
Hazlehurst, MS 39083

COVINGTON COUNTY
P.O. Box 667
Collins, MS 39428

DESOTO COUNTY
2535 Hwy. 51 S., Rm. 201
Hernando, MS 38632

FORREST COUNTY
P.O. Box 992
Hattiesburg, MS 39403

FRANKLIN COUNTY
P.O. Box 267
Meadville, MS 39653

GEORGE COUNTY
355 Cox Street, Ste. C
Lucedale, MS 39452

GREENE COUNTY
P.O. Box 310
Leakesville, MS 39451

GRENADA COUNTY
P.O. Box 1517
Grenada, MS 38902

HANCOCK COUNTY
152 Main Street, Ste. B
Bay St. Louis, MS 39520

HARRISON COUNTY
P.O. Box 998
Gulfport, MS 39502

HINDS COUNTY
P.O. Box 327
Jackson, MS 39205

HOLMES COUNTY
P.O. Box 718
Lexington, MS 39095

HUMPHREYS COUNTY
P.O. Box 696
Belzoni, MS 39038

ISSAQUENA COUNTY
P.O. Box 27
Mayersville, MS 39113

ITAWAMBA COUNTY
201 W. Main Street
Fulton, MS 38843

JACKSON COUNTY
P.O. Box 998
Pascagoula, MS 39568

JASPER COUNTY
P.O. Box 447
Bay Springs, MS 39422

JEFFERSON COUNTY
P.O. Box 305
Fayette, MS 39069

JEFFERSON DAVIS COUNTY
P.O. Box 1090
Prentiss, MS 39474

JONES COUNTY
P.O. Box 1336
Laurel, MS 39441

KEMPER COUNTY
P.O. Box 130
De Kalb, MS 39328

LAFAYETTE COUNTY
1 Courthouse Sq., Ste. 101
Oxford, MS 38655

LAMAR COUNTY
P.O. Box 369
Purvis, MS 39475

LAUDERDALE COUNTY
P.O. Box 1005
Meridian, MS 39302

LAWRENCE COUNTY
P.O. Box 1249
Monticello, MS 39654

LEAKE COUNTY
P.O. Box 67
Carthage, MS 39051

LEE COUNTY
P.O. Box 762
Tupelo, MS 38802

LEFLORE COUNTY
P.O. Box 1953
Greenwood, MS 38935

LINCOLN COUNTY
301 S. First Street, Rm. 205
Brookhaven, MS 39601

LOWNDES COUNTY
P.O. Box 31
Columbus, MS 39703

MADISON COUNTY
P.O. Box 1626
Canton, MS 39046

MARION COUNTY
250 Broad Street, Ste. 1
Columbia, MS 39429

MARSHALL COUNTY
P.O. Box 459
Holly Springs, MS 38635

MONROE COUNTY
P.O. Box 843
Aberdeen, MS 39730

MONTGOMERY COUNTY
P.O. Box 765
Winona, MS 38967

NESHOBA COUNTY
401 E. Beacon Street, Ste. 110
Philadelphia, MS 39350

NEWTON COUNTY
P.O. Box 447
Decatur, MS 39327

NOXUBEE COUNTY
P.O. Box 431
Macon, MS 39341

OKTIBBEHA COUNTY
108 W. Main Street
Starkville, MS 39759

PANOLA COUNTY
P.O. Box 346
Batesville, MS 38606

PEARL RIVER COUNTY
P.O. Box 530
Poplarville, MS 39470

PERRY COUNTY
P.O. Box 198
New Augusta, MS 39462

PIKE COUNTY
P.O. Drawer 31
Magnolia, MS 39652

PONTOTOC COUNTY
P.O. Box 428
Pontotoc, MS 38863

PRENTISS COUNTY
P.O. Box 727
Booneville, MS 38829

QUITMAN COUNTY
220 Chestnut Street, Ste. 4
Marks, MS 38646

RANKIN COUNTY
P.O. Box 1599
Brandon, MS 39043

SCOTT COUNTY
P.O. Box 371
Forest, MS 39074

SHARKEY COUNTY
P.O. Box 218
Rolling Fork, MS 39159

SIMPSON COUNTY
P.O. Box 307
Mendenhall, MS 39114

SMITH COUNTY
P.O. Box 517
Raleigh, MS 39153

STONE COUNTY
323 E. Cavers Avenue
Wiggins, MS 39577

SUNFLOWER COUNTY
P.O. Box 880
Indianola, MS 38751

TALLAHATCHIE COUNTY
P.O. Box 86
Charleston, MS 38921

TATE COUNTY
201 Ward Street
Senatobia, MS 38668

TIPPAH COUNTY
102-A N. Main Street
Ripley, MS 38663

TISHOMINGO COUNTY
1008 Battleground Drive,
Rm. 2014
Iuka, MS 38852

TUNICA COUNTY
P.O. Box 184
Tunica, MS 38676

UNION COUNTY
P.O. Box 298
New Albany, MS 38652

WALTHALL COUNTY
200 Ball Avenue, Ste. C
Tylertown, MS 39667

WARREN COUNTY
P.O. Box 351
Vicksburg, MS 39181

WASHINGTON COUNTY
P.O. Box 1276
Greenville, MS 38702

WAYNE COUNTY
P.O. Box 428
Waynesboro, MS 39367

WEBSTER COUNTY
P.O. Box 308
Walthall, MS 39771

WILKINSON COUNTY
P.O. Box 327
Woodville, MS 39669

WINSTON COUNTY
P.O. Drawer 785
Louisville, MS 39339

YALOBUSHA COUNTY
P.O. Box 1431
Water Valley, MS 38965

YAZOO COUNTY
P.O. Box 108
Yazoo City, MS 39194

APPENDIX A TO MISSISSIPPI APPLICATION FOR HEALTH COVERAGE

HEALTH COVERAGE FROM JOBS

If someone in the household is eligible for health coverage from a job, please complete this form. Complete this form for each job that offers coverage, using separate forms for each job. Take this form to the employer to help complete the health coverage questions if needed. Complete the form for each household member eligible for health coverage through a job, even if it is from another person's job, like a spouse or parent of a child under age 26.

Name of employee: _____ **SSN:** _____

Employer Information	Employer ID # (EIN)
Name of Employer:	
Address of Employer:	
City	State Zip
Phone #	Email
Contact Person Regarding Health Coverage:	

Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months? __ Yes (Continue) __ No (Stop here)
If you are in a waiting period or probationary period, when can you enroll in coverage? _____
List the names of anyone else who is eligible for coverage from this job.
Name: _____
Name: _____
Name: _____

Tell us about the health plan offered by this employer:

Does the employer offer a health plan that covers an employee's spouse or dependent? □ No □Yes – which people? □ Spouse □ Dependent

Does the employer offer a health plan that meets the minimum value standard? □ Yes □ No A*n employer-sponsored health plan meets the minimum value standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Sec. 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)*

For the lowest cost plan that meets the minimum value standard offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

Employee premiums for this plan $_____. How often? _____

What change will the employer make for the new plan year (if known)?

□ Employer will not offer health coverage

□ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard (premium should reflect the discount for wellness programs). Premium amount $ _____ How often? _____

Date of change:_____