YOUR RIGHTS

Information about your Coverage and Rights:

You have a RIGHT to request, and if found eligible, to receive financial or Medicaid or Supplemental Nutrition Assistance Program benefits based on policies and standards established under State and Federal laws and regulations.

You may have the right to appeal and have an Administrative Fair Hearing if you disagree with our decisions. You may:

1. **Call us to discuss the benefit decision.** Contact us at the telephone number at the top of the first page of this notice. Be sure to have this notice and the case/identification number on-hand when you call.
2. **Appeal for an Administrative Fair hearing.** An Appeal is a formal request asking for the decision to be reviewed at an administrative hearing. Please continue reading for further information.

What is a fair hearing?
A fair hearing is a chance for you to tell an administrative hearing officer why you disagree with the agency's decision about your eligibility, benefits, and/or any costs you must pay. An agency representative is also present at the hearing to explain the basis for the agency decision. By law, the administrative officer must review the facts of the case presented by both sides in a fair and objective manner.

Deadlines for appeals and asking for a fair hearing
The chart below explains the deadlines for filing an appeal for each program. For some programs, your benefits or services may be continued until a hearing decision is made if you appeal by the deadlines listed in the chart. If you miss this deadline, you may lose your right to appeal. After you have filed your appeal, we will schedule your hearing and issue a decision within 90 days, or 60 days if the hearing relates to your SNAP benefits. A decision will issue on all HealthSource RI appeals within 90 days of the date an appeal request is received, as administratively feasible.

Program	You must file an appeal in:	Will benefits continue if the appeal is made within 10 days of the notice ("Aid Pending")?
Medicaid	30 days after the notice date plus five days for mailing time	Yes, benefits will automatically continue unless you tell us otherwise
SNAP	90 days from the notice mail date	Yes, benefits will automatically continue unless you tell us otherwise
CCAP	30 days from the notice mail date	Benefits may be reduced until a hearing decision is made.
GPA	10 days from the notice mail date	Yes, but the request must be made in writing
Commercial Health Insurance	30 days after the notice date plus five days for mailing time.	You must call HealthSource RI within 30 days of the notice to request Aid-Pending.
All other programs	30 days from the notice mail date	Yes

Expedited Appeals
You have the right to an expedited appeal if you have an immediate need for health services or SNAP benefits and waiting for a standard appeal could seriously jeopardize your life or health, or ability to attain, maintain, or regain maximum function. We must decide expedited appeals as quickly as possible, given the circumstances. If we deny your request for an expedited appeal, we must inform you quickly, and we must handle your appeal through our standard process.

Right to Continue Benefits While Awaiting Hearing
You may have the right to have your benefits continue unchanged while you wait for your hearing (this is called "Aid-Pending"). Except for Commercial Health Insurance through HealthSource RI, if you appeal within 10 days, in most instances, you will be automatically granted Aid-Pending. Unless you can show otherwise, for Medicaid and HealthSource RI, we will assume that you received the notice 5 days after the date on the notice.

If you have Medicaid and you receive Aid-Pending, and then you lose your appeal, the State may make you pay back its costs for covering you during the Aid-Pending period. For HealthSource RI, Aid-Pending is only available if you are appealing an eligibility redetermination that occurred within 30 days of the date you file your appeal, and the request is made by telephone to HealthSource RI at 1-855-840-HSRI (4774). If you are receiving tax credits to help pay for your premiums and you receive Aid-Pending, and then you lose your appeal, then you may owe extra money in your federal taxes next year. If you pay monthly premiums, you must still pay during the Aid-Pending period.

If you receive SNAP, RIW or GPA benefits and receive Aid-Pending, and you lose your appeal, you may need to pay back the benefits you were issued but were not entitled to during this period.

Right to Represent Yourself and Right to be Represented
You have the right to represent yourself at the hearing, or to be represented by anyone you choose, including an attorney, advocate, friend, or relative.

Legal advice is available from Rhode Island Legal Services, Inc. at 274-2652 or 1-800-662-5034. If you choose to have Legal representation, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the Legal representative access to the Agency case record. It is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

Eligibility of Other Household Members May be Affected
Our appeal decision may result in changes to the eligibility of another member of your household.

Access to Your Case Record
You have the right to see your case record, including any evidence the State will use at your hearing. To view your case record, call us at 1-855-MYRIDHS (1-855-697-4347). If you are appealing an action taken by HealthSource RI, you may request a copy of your record by calling: 1-855-840-HSRI (4774).

Informal Resolution
We may be able to fix your problem quickly without a hearing. Please call 1-855-MYRIDHS (1-855-697-4347) so that we can review your case informally. If you are appealing an action taken by HealthSource RI, you may contact HealthSource RI at 1-855-840-HSRI (4774) to request an informal review of your appeal. We will reach out to you in an effort to resolve your appeal informally. Your right to a hearing will not be impacted by efforts to resolve your issue informally.

You have a RIGHT to confidentiality. Under state law, all agencies administrating programs are bound by state and federal laws and regulations to use information about you and other members

of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information. HIPAA restrictions prevent us from discussing the health information of you or any member of your household with anyone, including unauthorized representative, unless that individual has power of attorney or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results or treatment and chemical dependency services.

The EOHHS and DHS do not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12, 40-6-12.1, and 42-7.2-5(13), regulations set forth in the DHS Administrative Code and Medicaid Codes of Administrative Rules. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars ($200), or imprisonment of up to six (6) months, or both.

You have a RIGHT to apply for support enforcement services through the Office of Child Support Services. To get an application for these services, go to **http://www.cse.ri.gov/** or visit your local Office of Child Support Services at 77 Dorrance St., Providence, RI 02903.

You have a RIGHT to name an authorized representative. An authorized representative is a person designated by the head of the household or the spouse, or any other responsible member of the household, to act on behalf of the household in applying for program benefits, or using the benefits. The authorized representative for benefits may or may not be the same individual designated as an authorized representative for the application process or for meeting reporting requirements. The authorized representative designation must be made in writing.

YOUR RESPONSIBILITIES

Information about your Coverage and Responsibilities:

You have a RESPONSIBILITY to supply accurate information about your income, resources and living arrangements on this application.

Premium Tax Credit Information

You may choose to defer some of your health insurance tax credit amount and receive the balance when you file your federal taxes. You may be responsible for repaying tax credits when filing your federal taxes if the amount you apply to your monthly premium exceeds the amount you are eligible for based on your total annual income.

In order to be eligible for the health insurance tax credits, you must comply with the following requirements:

- File taxes for the year in which you are receiving health insurance coverage.
- Report any changes affecting your eligibility as required above.

Cost Sharing Reductions Information

Based on your income, you can receive more financial assistance for insurance. Cost sharing reductions bring down the amount you have to pay for your health care out-of-pocket (in other words for medicines at the drug store or for co-pays at the doctor's office). For instance, if your income goes down, your copays or deductibles may be lowered. The level of reductions depends on your household income. If your household income changes, your copays and deductibles may also change.

You have a RESPONSIBILITY to provide Social Security numbers (or proof that you have applied for one) for yourself and the members of your household, as a condition of eligibility. The collection of information on the application, as well as the Social Security numbers of all members of your household for whom you receive assistance, is authorized under the Food and Nutrition Act of 2008 (formerly the Food Stamp Act), as amended, 7 U.S.C. 2011-2036 and under Federal Law (45 CFR 155.305 and 42 CFR 435.910). This information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP, Medicaid, RIW, GPA, CCAP, and/or Commercial Health Insurance with Financial Help. The Department will verify this information through computer matching with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Service, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of SNAP benefits, GPA, Child Care, RIW, Medicaid, and Commercial Health Insurance with Financial Help. This information will also be used to monitor compliance with program regulations, for program management as well as to prevent fraud and verify health care claims.

This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a claim arises against your household, the information you provided on your application, including all SSNs, may be referred to Federal and State agencies as well as private claims collection agencies for claims collection action. Providing the requested information is voluntary. However, failure to provide a SSN will result in the denial of benefits to any individual applying for benefits. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

You have a RESPONSIBILITY to cooperate fully with state and federal personnel conducting quality control reviews.

You have a RESPONSIBILITY to cooperate with the Office of Child Support Services if you receive RI Works, Child Care Assistance or Medicaid. You must help establish, modify, or enforce child support for the child(ren) in your care, and establish paternity (if necessary). If you can show that you have a good reason to believe that cooperating with the Office of Child Support Services puts you, your children, or the children in your care at risk of harm from the non-custodial parent, you may claim good cause not to cooperate.

RI WORKS PROGRAM, MEDICAID, CHILD CARE ASSISTANCE AND GENERAL PUBLIC ASSISTANCE LIENS AND ASSIGNMENTS

Pursuant to Rhode Island General Law, Sections 40-6-9, 40-6-10, or 40-8-15, without the necessity of signing any document:

a.) Regarding Child Support and Establishment of Paternity

I have assigned any and all rights that I may have for and on behalf of myself, and for and on behalf of my child or children, to the Department of Human Services (DHS) whether acting on its own or as an eligibility agent of the Executive Office of Health and Human Services (EOHHS), against any person failing to provide for support, maintenance, and medical care for myself and my minor child or children for whom assistance is paid by either or both agencies. In this capacity, the DHS is authorized to institute a suit to establish paternity and/or to collect support for myself or my child or children who receive or received assistance from the DHS and/or EOHHS. If I stop getting financial assistance or Medicaid, I must tell the Office of Child Support Services about any changes that affect child/medical support such as if my child moves out of my home or there is a change in my address.

b.) Regarding Amounts Recoverable from a Third Party

I have assigned any and all rights to the DHS or EOHHS, for and on behalf of myself and any person who I am legally authorized to represent, for amounts recoverable from a third party equal to the amount of financial assistance and Medicaid provided as a result of accident, injury, or illness.

c.) Regarding Amounts Recoverable from Workers' Compensation

The Department of Human Services and/or Executive Office of Health and Human Services may place a lien upon any pending award, order, or settlement, which I may be entitled to under the provisions of the Rhode Island Workers Compensation Act, Chapters 28-29 through 28-38 of the Rhode Island General Laws. The purpose of the lien is to secure reimbursement to the State for financial and Medicaid payments made to me or on my behalf for the period of time for which workers' compensation award, order, or settlement is made.

d.) Regarding Lien on Deceased Recipient's Estate for Medicaid Reimbursement

In accordance with R.I.G.L. 40-8-15, the EOHHS may place a lien upon the estate of a Medicaid recipient who was fifty-five (55) years of age or older at the time of death. For purposes of this section the term "estate" with respect to a deceased individual shall include all real and personal property and other assets included or includable within the individual's probate estate. The total sum of Medicaid paid on behalf of a Medicaid recipient who was fifty-five (55) years of age or older at the time of receipt is a debt to the state and constitutes a lien upon the estate of the recipient in favor of the EOHHS. However, the lien is effective and does not apply to the estate of a recipient who is survived by a spouse, or a child who is under the age of twenty-one (21) or a child who is blind or permanently and totally disabled as defined in Title XVI (SSI) of the Social Security Act. Tribal lands and certain properties belonging to American Indians and Alaskan Natives may be exempt from recovery.

Understand that your application will serve as authorization to the Department of Human Services to obtain from Medical providers information that is pertinent to you or any person included in your application for as long as the case remains open.
Understand and agree that the DHS office may contact other persons or organizations to obtain the necessary proof of your eligibility and level of benefits.

I also understand that EOHHS and DHS can use or share information I provided on my application and in my private account for the administration of any programs for which I applied and/or may be providing me with benefits in accordance with state and federal law, contract and regulation. The EOHHS and DHS can release non-identifying information for research purposes. Any release of identifying information must be done in accordance with state and federal law.

Commercial Health Insurance Plan: Termination by You

You may terminate health insurance coverage for any member of your household at any time. Their coverage will end on the last day of the month in which you submit your request. For example, if you request to terminate your coverage on May 17th, your last day of coverage would be May 31st. Please note: you may have to pay a penalty if you do not have health insurance coverage.

Commercial Health Insurance Plan: Termination by Your Carrier or by the Exchange

The following member(s) of your household may be enrolled in a Commercial Health Insurance Plan:

Name
[redacted]

Your coverage, or the coverage for any member of your household in a commercial Health Insurance plan can be cancelled only if the following things happen:

- if you or your household member are no longer eligible for affordable coverage through Medicaid or HealthSource RI
- if you or your household member does not pay premiums and your grace period ends (45 CFR § 155.430(b)(2)(ii)),
- if you or your household member's coverage is ended due to fraudulent information in your application,
- if you or your household member's insurer goes out of business, loses its license or certification under state law, and
- if you or your household member changes to another plan offered on HealthSource RI during an open or special enrollment period.

If you have special health care needs

You and members of your household might qualify for more services through Medicaid if anyone in your household has special health care needs.

- Does anyone in your household have a disability?
- Does anyone in your household need nursing home care or other long term care services?
- Does anyone in your household have high or frequent medical bills?

If so, find out if they qualify based on special health care needs. Call (855) 712-9158 or visit www.HealthSourceRI.com for more information.

Date : 05/13/2023
Account Number [redacted]

STATE OF RHODE ISLAND
P.O. BOX 8709
CRANSTON, RI 02920-8787

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Account #: [redacted]

APPEAL FORM

Appeal Request Process

You may request an appeal by doing one of the following below. If you submit this form, the state will complete a review of your case to try to resolve the issue.

- **Online.** Log into your account at https://healthyrhode.ri.gov and click on "file an appeal".
- **By phone.** You can file an appeal regarding Medicaid and Purchased Health Coverage through HealthSource RI by calling HealthSource RI at 1-855-840-HSRI (4774). For questions about filing an appeal for human services programs such as SNAP, RIW, Child Care, GPA, or SSP call the Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347).
- **In person.** For in-person assistance visit **www.dhs.ri.gov** to view office locations.
- **By mail.** Complete this form and mail it to ATTN: Appeals STATE OF RHODE ISLAND, P.O. BOX 8709, CRANSTON, RI 02920-8787.

Name (required): _____

Date of Birth (required): _____

Account Number (as displayed at the top of the notice): _____

Address (required): _____

Phone number: _____

Email: _____

Do you need help speaking, reading or writing English? ☐ Yes ☐ No:

If yes, what is your primary language? _____

Preferred method of contact (circle one): email / paper mail

You must check off the reason(s) for your appeal:

Health Coverage:	Human Services:		
_____ Medicaid	_____ SNAP	_____ GPA	
_____ Purchased plan through HSRI	_____ RIW	_____ CHILD CARE	
_____ Both/Unsure	_____ SSP		

_____ Other (Please explain) _____

Account #: [redacted]

Please explain the reason for your appeal:

Do you need important health services or SNAP benefits immediately? If so, would you like an expedited appeal? ☐ Yes ☐ No:

If yes, Please explain:

IF THE HEARING DECISION IS NOT IN MY FAVOR, I UNDERSTAND THAT I MUST REPAY ANY ASSISTANCE AND/OR SNAP BENEFITS FOR WHICH I AM DETERMINED INELIGIBLE

☐ Check this box if someone is going to help you with the appeal or represent you during the appeals process. This can be an attorney, friend, or family member. Provide this person's contact information:

Name:

Phone:

Address:

Email:

Would you like your coverage and benefits to continue unchanged while you wait for a hearing decision? ☐ Yes ☐ No:

Signature _____ Date _____

(Recipient)

TO BE COMPLETED BY THE AGENCY ONLY:

APPEAL IS ABOUT: _____ RIW _____ MEDICAID _____ GPA _____ SNAP _____ PURCHASED HEALTH PLAN _____ CHILD CARE _____ OTHER

Indicate Specific Policy Manual Reference: Section(s) _____

Agency response to appeal/explanation: _____

Agency Representative (Signature) _____ Supervisor(Signature) _____

(Print Name) _____ (Print Name) _____

Local Office _____