State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

SAUL M. KILSTEIN
DIRECTOR

QUAKERBRIDGE PLAZA
CN 712
TRENTON, NEW JERSEY 08625-0712

MEDICAID COMMUNICATION NO: 91-19 **DATE:** July 25, 1991

TO: County Welfare Agency Directors

SUBJECT: Revised Fair Hearing Request

In an effort to assist with expediting the preliminary phase of the recipient fair hearing process, the fair hearing request form has been revised. The revised form was designed to obtain the necessary client information directly from the recipient, thereby expediting the initial filing process.

Please note that, in addition to the language revisions on the request, we have eliminated the tear-off section of the form. The client is now instructed to send the original form, or a legible copy of both sides of the form, to the address specified. Accordingly, the majority of the information required for the Division to initiate the fair hearing will now be provided by the county welfare agency, minimizing the need for the Division to contact the county welfare agency for additional information. The only information the client will be providing is his/her reason for requesting a fair hearing, and if their benefits have been terminated, whether they wish to have their benefits continue until a final decision has been reached.

Once a client's request for a fair hearing has been received by the Fair Hearing Unit, a copy of that completed request will be forwarded to the county welfare agency. This will alert the county welfare agency of the request for a fair hearing and the election to continue benefits so that necessary action may be taken to update the eligibility file.

After a fair hearing has been completed and a final decision has been made, a copy of the Final Agency Decision (FAD) will be forwarded to the appropriate county welfare agency. This will serve as the Director's instruction to that agency to implement that decision.

A prototype of the revised fair hearing request is attached to this communication. The format is such that it can be easily duplicated on your agency letterhead.

Questions concerning this communication should be referred to the field staff assigned to your county.

Sincerely,

Saul M. Kilstein
Director

SMK:PTd
Attachment

cc: Marion Reitz, Director
Division of Economic Assistance

Nicholas Scalera, Director
Division of Youth and Family Services

To: _____ Re: _____

_____ Program: _____

_____ Case # _____

_____ Date: _____

This notification is to advise you of the following decision concerning your eligibility for the Medicaid program.

___ Eligible effective _____ ___ Terminated effective _____

___ Denied

This action has been taken because: _____

_____

This action is required by the following regulations: _____

_____

FAIR HEARING NOTICE

You have the right to request a fair hearing on this action. You must request a fair hearing within 20 days of the date of this letter. If you have been receiving Medicaid benefits and request a fair hearing within the 20-day period, your Medicaid benefits may continue until a hearing decision is reached so long as you remain eligible in all respects. **However, if the fair hearing decision is not in your favor, you may be required to repay any Medicaid benefits to which you were not entitled.**

FAIR HEARING REQUEST

To request a fair hearing, complete this section in full and send a legible copy of this form to:

Division of Medical Assistance and Health Services
Fair Hearing Unit
CN-712
Trenton, New Jersey 08625

If you require assistance, please call (609)588-2655.

I want a fair hearing because: _____

_____

Only if your Medicaid benefits were terminated, check one:

___I wish to continue my Medicaid benefits.
___I do not wish to continue my Medicaid benefits.

If other than the applicant/recipient completed this request please complete:

Name of representative _____ Telephone # _____

Address _____

_____

YOUR RIGHTS

Concerning the fair hearing, you have the right to :

- Present your own case or have a relative, friend, or attorney make the presentation.
- Submit any evidence and/or bring any witnesses that bear on your case.
- Examine records or case files including the application form. You may also examine the case record in advance except for those records which are protected from release and which may not be introduced by the county welfare agency as evidence.
- Review a complete and up-to-date copy of the Medicaid Only Manual.

Regarding Legal Services

You have the right to legal counsel at your fair hearing. For individuals who cannot afford to pay for the services of an attorney, there are private legal services organization available which provide free legal counsel.

If you wish free legal counsel, you may consult with _____

_____

If you have been denied eligibility or have had your eligibility terminated, you have the right to reapply for Medicaid benefits if there is any change in your current circumstances.

Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the grounds of race, color, national origin, age, or handicap in the administration of any program for which Federal funds are received.

_____ _____

Eligibility Worker's Name Telephone Number

_____ _____

Eligibility Worker's Signature Date