FSSA Document Center
PO Box 1810
Marion, IN 46952

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Eligibility Notice for Health Coverage

Indiana Family and Social Services Administration
PO Box 1810
Marion, IN 46952
Phone/Fax: 1-800-403-0864

Payee Name : [redacted]

Case Number : [redacted]

AG Number : 43141419

Program : Health Coverage

Mailing Date : JANUARY 19, 2023

[redacted]

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

It's time for your Medicaid/Hoosier Healthwise/Healthy Indiana Plan (HIP) eligibility review. We need to review your situation and complete a redetermination of eligibility in order for your health coverage to continue. To continue your coverage for another year we need you to complete, sign and return this form.

If you do not complete, sign and return this form your coverage will be discontinued effective MARCH 01, 2023.

YOU MUST INCLUDE PROOF OF YOUR CURRENT INCOME WITH THE FORM.

We may request further proof of any changes and will notify you in writing if we need additional proof. Failing to provide requested documents or information could affect your eligibility for health coverage.

Sign the enclosed Medicaid/Hoosier Healthwise/HIP Eligibility Review Form and return it to us by the due date shown on the form. If you have any questions, please call the FSSA Call Center at 1-800-403-0864 between 8:00 a.m. and 4:30 p.m.

Return your completed form and any additional documents to:

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or Fax to the FSSA Document Center at 1-800-403-0864.

Or you may also take your completed form to the Office of Family Resources in your county. The locations of these offices are available at www.fssa.in.gov or by calling 1-800-403-0864.

New! You can now submit information for your redetermination online using the FSSA Benefits Portal at fssabenefits.in.gov. You will need to create an account, if you have not already done so. You can report any changes, upload documents, and electronically sign your redetermination form. **You will need to submit your income from the last 30 days to complete your redetermination**. If we need more information from you after you submit information online, we will send you a separate request.

WHOSE ELIGIBILITY IS BEING REVIEWED?

The Medicaid/Hoosier Healthwise/Healthy Indiana Plan Eligibility Review Form lists the people shown in this case. Each person is shown as either "eligible" or "ineligible" which is the member's status in this case. We are currently reviewing the circumstances of the family in this case. It may be possible that someone shown as ineligible is receiving health coverage in another case. If that is true, please just write in the space provided: "receiving Medicaid/Hoosier Healthwise/HIP" as appropriate in the space available under “correction”.

If anyone's tax filing status has changed or expects to change from the previous year when Medicaid eligibility was determined, you are required to report this change. Such changes would include who files taxes or doesn't file taxes, and it would also include whether a dependent is claimed by a different person than the previous year.

Thank you.

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MEDICAID/HOOSIER HEALTHWISE/HIP ELIGIBILITY REVIEW

It is time for the annual review of your eligibility for Medicaid/Hoosier Healthwise/HIP. This is information we show currently in your case. If there are changes, please write them in the space provided and provide documentation of the new information.

PLEASE RETURN THIS FORM AND DOCUMENTS TO US NO LATER THAN FEBRUARY 20, 2023.

DON'T FORGET TO SIGN YOUR FORM ON THE LAST PAGE

HOME ADDRESS:				
ADDRESS LINE1	ADDRESS LINE2	CITY, STATE ZIP	PHONE	OTHER PHONE
[redacted]	[redacted]	Indianapolis, IN 46204-1380	[redacted]	
CHANGES/CORRECTIONS				

MAILING ADDRESS:		
ADDRESS LINE1	ADDRESS LINE2	CITY, STATE ZIP
CHANGES/CORRECTIONS		

We show the following persons living in your household. (This includes an eligible member who may be living in a health care or residential facility.) Please make any corrections in the third column such as a name change or correct spelling, a correction to birth date or comment "no longer living here". If an eligible Medicaid/Hoosier Healthwise/HIP member is no longer living at this address please give the current address if you know it.

NAME	BIRTH DATE	CURRENT STATUS	CORRECTION
[redacted]	[redacted]	Eligible	
[redacted]	[redacted]	Ineligible	
List Additional household members and their relationship to eligible members:			

EMPLOYMENT INFORMATION:

Attach pay stubs for the last 30 days or provide a statement from your employer for each employed member.

EMPLOYED MEMBER	EMPLOYER	GROSS EARNINGS	FREQUENCY
[redacted]	5	$480.00	Weekly
CHANGES/CORRECTIONS			

SELF EMPLOYMENT INFORMATION:

Attach a copy of your most current income tax return including all schedules. If you do not file taxes, we need a copy of your self-employment records of income and expenses for the past twelve (12) months.

SELF-EMPLOYED MEMBER	EMPLOYEE	TYPE	GROSS EARNINGS	FREQUENCY
CHANGES/CORRECTIONS				

OTHER INCOME INFORMATION:

Attach proof of the amount of each income type received for the most recent full month. If you wish, you may include in your attachment more than one month of income for each type. Supplemental Security Income (SSI) is not counted, child support, and veterans' benefits are not counted for Hoosier Healthwise and HIP.

RECEIVED BY	TYPE OF INCOME	AMOUNT RECEIVED	FREQUENCY
[redacted]	Child Support (CHSD) - System Direct (from IV-D)	$0.00	Monthly
[redacted]	Child Support (CHSD) - System Direct (from IV-D)	$170.89	Monthly
CHANGES/CORRECTIONS			

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ADDITIONAL INFORMATION: IF YOU HAVE ADDITIONAL INFORMATION TO REPORT, PLEASE ENTER THAT INFORMATION BELOW AND ATTACH DOCUMENTATION OF THE CHANGE.

Do you want to register to vote? (This will not affect your health coverage benefits.) ___Yes ___No

YOUR SIGNATURE IS REQUIRED:

I certify under penalty of perjury that the information provided on this form is correct and complete to the best of my knowledge and belief.

_____ _____

Signature Date signed (month, day, year)

Witness signature if above is signed with "X" _____

PLEASE MEET THE REQUESTED DEADLINE SO THAT WE CAN PROCESS YOUR ELIGIBILITY REVIEW WITHOUT DELAY.

You may receive a request from us if we need additional information or proof of any changes that you have indicated or that we discover. You will also receive a notice on whether your health coverage benefits will continue or end based on your eligibility redetermination.

THANK YOU VERY MUCH FOR YOUR COOPERATION.

If you disagree with our decision

You have the right to appeal our determinations such as your monthly income, POWER account contribution amount, or category of benefits. This notice includes instructions for filing an appeal. Please read this information carefully.

Timelines and process for appealing

You must file your appeal in writing by close of business within thirty-three (33) days of the date of the notice or the effective date of the action you are appealing, whichever is later. Please note that close of business means 4:30 pm local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal by the next business day. If you mail your appeal, your appeal will be considered filed on the date of receipt and not on the postmarked date.

An FSSA representative will notify you of the next steps. If FSSA schedules a hearing we will notify you in writing of the date, time, and place for the hearing. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative.

How will the appeal impact my benefits?

If you submit your request for the appeal prior to the effective date of the change in your coverage listed in this notice, you will be able to receive the same level of benefits you are currently receiving while your appeal is pending. However, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contribution during your appeal in order to continue receiving HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you will lose access to HIP Plus or HIP State Plan Plus benefits and you may lose your HIP eligibility.

You should expect a short delay in having your current coverage continue if we receive your appeal request near the deadline, but we will restore the benefits retroactively so that you have no break in coverage.

If you submit your request for appeal after the effective date of the change in your coverage listed in this notice, you will receive your new benefits while your appeal is pending.

Can I maintain my current benefits during the appeal?

As indicated in this notice, you will maintain your current HIP benefits while your appeal is pending if you submit your request for appeal prior to the effective date of the discontinuation of benefits listed in this notice. However, if your benefits were discontinued because you did not make a timely POWER account contribution or premium payment, then you may not maintain benefits during your appeal. Also, if you are enrolled in HIP Plus or HIP State Plan Plus, you must continue making the required monthly POWER account contribution during your appeal in order to continue receiving HIP Plus or HIP State Plan Plus benefits. Your appeal does not remove this requirement. If you do not make your required POWER account contributions on time during your appeal, you will lose access to HIP Plus or HIP State Plan Plus benefits and you may lose your HIP eligibility.

Back payments for HIP POWER account

If you become ineligible for any HIP services and the administrative law judge at the hearing for your appeal rules in your favor, your coverage will be restored back to the appropriate date in which you should have been found eligible. Importantly, you will be responsible for paying back any missed POWER account contributions that accrued during your appeal. You will lose HIP eligibility if you do not repay this amount timely.

How to file an appeal

You can mail, fax, or hand deliver your written appeal request.

To appeal, please send a signed letter with as much information as possible including your Name, Case Number, and Reason for the appeal, along with a copy of this entire notice to one of the following locations listed below. For your case, this information is provided below for your convenience.

Name: [redacted] Case Number: [redacted]

Date of Notice: JANUARY 19, 2023 County: 49

1. Mail your written appeal to:

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or,

2. Fax your written appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

FOR MORE INFORMATION ABOUT THE FAIR HEARING PROCESS

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

Local Office of Family Resources

MARION COUNTY DFR
3266 N Meridian St
Ste 1024
Indianapolis, IN 46208
PHONE: 1-800-403-0864