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**NOTICE AND HEARINGS PROCESS**

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**MA-2420 NOTICE AND HEARINGS PROCESS  
REISSUED 10/01/11 – CHANGE NO. 18-11**

**I. INTRODUCTION**

This section contains the regulations and procedures for notifying the applicant/recipient (a/r) of case action/status and for conducting local and State hearings.

**II. POLICY PRINCIPLES**

**A. An a/r has the right to a written notice when:**

1. An inquiry about Medicaid is made. Use the DMA-5095/DMA-5095S, Medicaid/Work First Notice of Inquiry, for inquiry documentation.
2. An application is approved or benefits are continued. Use the automated DSS-8108A/DSS-8108S, Notice of Benefits, or use the manual DMA-5002/DMA-5002S, Approval Notice.

Caseworkers must manually add the following sentence to the DMA-5002 approval notices that do not contain information about Medicare Part D: “If you receive Medicare, Medicare is responsible for your prescriptions.”

When approving Medicaid for Family Planning services, add the following sentence to the DMA-5002/DMA5002S, Approval Notice, if it does not contain the information: “Your partner may be potentially eligible also.”

3. An application is denied or withdrawn. Use the automated or the manual DSS-8109/DSS-8109S, Notice of Benefits Denied or Withdrawn, to notify the applicant of the denial/withdrawal.
4. Benefits are changed, reduced, or terminated. Use the automated or the manual DSS-8110/DSS-8110S, Notice of Change in Benefits, to notify the recipient of both timely and adequate changes or terminations. For Medicare recipients, manually add the following sentence to the manual DSS-8110 that does not contain information about Medicare Part D: “Now that you are enrolled/receiving Medicare, Medicaid will not pay your prescriptions. Medicare is responsible for your prescriptions.”

**B. An a/r has the right to appeal an action if he disagrees with the county dss' decision.**

**C. In certain situations, an a/r has the right to have his benefits continued until a hearing decision is rendered.**

**D. A local hearing must be held at the county dss for all appeals, except for those involving a determination of disability. For appeals involving disability issues, including terminations at the end of ex parte reviews when the recipient claims he is still disabled, request a state hearing.**

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(II.)

**E. An a/r has a right to a State hearing if he disagrees with the county dss local appeal decision, or if the appeal involves a determination of disability. **The right to a state hearing includes instances where presumptive SSI benefits have ended, no disability determination has been made and an ex parte review determines that the individual is not eligible in any other aid program category.****

**III. AUTHORIZED REPRESENTATIVES ENTITLED TO NOTICE.**

**A. Hierarchy of Representatives**

Authorized Representative, power of attorney and guardian information must be keyed on the DSS-8125 so that this individual receives Medicaid and Special Assistance notices. Separate fields have been created on the DSS-8125 to allow for entry of PACE Agency or CAP Manager data in addition to Authorized Representative information. Key PACE Agency or CAP Manager information in the designated fields.

The following list of representatives is ordered by the highest priority representative first and the lowest last. When there is more than one type of representative, always choose the one with the higher priority.

1. Legal Guardian (includes DSS with custody or guardianship; if individual has a Guardian of the Person and a Guardian of the Estate, choose the Guardian of the Person).
2. Power of Attorney.
3. Health Care Power of Attorney.
4. Department of Social Services (placement responsibility only).
5. Spouse (Not separated).
6. Parent (for children under 21, a parent who is not the casehead but who lives in the home).
7. Authorized Representative (An individual designated in writing by the applicant/recipient to assist with eligibility issues and who can have access to the information in the case file).
8. Authorized Representative as designated by SSA on SDX.

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**B. Representative Information for Applications**

1. Contact the applicant and ask if he has any of the representatives listed in the hierarchy of representatives by reviewing the list with them. For LIS and mail-in applications, obtain the representative information during the phone interview. The individual may have more than one representative, therefore do not stop the inquiry when the individual provides one name. An individual can also have more than one power of attorney; if he has more than one ask him to choose one to receive notices. Document the applicant's response. If the individual is incapable of choosing, use the name of the Power of Attorney who has been helping with the case.

Note: If the application is being made by an informal representative, provide the representative with an authorized representative form, such as the [DMA-5018](#), for the applicant to sign.

2. Ask the language preference for each representative named. Document the applicant's response.
3. Guardianship and/or power of attorney papers
  - a. Request a copy of the guardianship and/or power of attorney document using the [DMA-5097/5097S](#).
  - b. If the individual does not respond to the initial request, send a second request.
  - c. If the individual does not respond to the second request and all other necessary information has been received, process the application within the normal time frame.
  - d. If the individual has more than one representative and has supplied documentation for only one, enter the information for the one that has been verified, even if the unverified representative has a higher priority.

**C. Hospital as Authorized Representative**

A hospital may be an Authorized Representative for an applicant, but the authorization may be limited to the application process, the application process and any hearing and appeal following a denial, or for another specified time (See VII.B.7. below for limited circumstances under which information can be released to a hospital which is not an authorized representative).

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1. The hospital must identify an individual to serve as the Authorized Representative. If an individual's name and contact number are not on the Authorized Representative form, contact the hospital and obtain this information.
2. If the individual has a representative of a higher priority than the hospital, enter the higher priority representative in the representative field. Enter the hospital Authorized Representative information in the PACE Agency/CAP Manager field on the DSS-8124, provided there is no PACE Agency or CAP Manager. If the individual has a representative of a higher priority and there is a PACE Agency or CAP Manager, the hospital Authorized Representative information cannot be entered. If there is a higher priority representative and a PACE Agency or CAP Manager, send copies of all notices to the hospital.
3. If the application is approved and the hospital is listed as Authorized Representative for the application process only, remove the hospital from the Representative Field or PACE Agency/CAP Manager field the day after approval (See III.D).
4. If the application is denied, maintain the hospital Authorized Representative information on the DSS-8124.

**D. Representative Information for Redeterminations**

1. No representative information in file
  - a. Ask the individual if he has a representative by reviewing the hierarchy of representatives list with him.
  - b. If the individual now has a legal guardian and/or power of attorney, request a copy of the guardianship and/or power of attorney document.
2. Representative information in file
  - a. Verify that the individual listed is still the current representative.
  - b. Ask the individual whether he has any new representatives. Review the hierarchy of representatives list with the recipient in making the inquiry.
  - c. If the individual has one or more new representatives, find out the language preference of each representative.
  - d. If the individual has an informal representative, mail a "Designation of Authorized Representative" form, such as the [DMA-5018](#), to the individual for signature.

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3. Guardianship and/or power of attorney documents
  - a. If there is a guardian or power of attorney document in the file, determine if it is still valid. If the document has expired or will expire during the redetermination process, request new document.
  - b. If the individual has a new legal guardian and/or power of attorney, request a copy of the guardianship and/or power of attorney document using the [DMA-5097/DMA-5097sp](#).
  - c. If the individual does not respond to the request for information, complete the redetermination within the normal time frame. If the individual provides the information after the redetermination is completed, key the information when received.

**E. SSI Cases**

1. If there is no Authorized Representative information in EIS, Authorized Representative information from the SDX will automatically populate to the DSS-8125.
2. If there is Authorized Representative information in EIS, Authorized Representative information from SDX will not overlay the existing information. The Authorized Representative information from SSA is written to a report on NCXPTR (See V.A).
  - a. If the Authorized Representative information in XPTR is the same as that contained in EIS, no change is needed.
  - b. If the Authorized Representative information in XPTR conflicts with that in EIS, contact the recipient and ask which Authorized Representative is current. If the Authorized Representative has changed, request a copy of the new Authorized Representative document from the recipient. Key the new information into the DSS-8125 when the documentation is received.

**F. Keying Authorized Representative, PACE Agency and CAP Manager Information**

1. AUTHREP Field on the DSS-8124

If the a/r has an Authorized Representative, PACE Agency or CAP Manager, enter a “Y” indicator in the “AUTHREP” field on the DSS-8124. If not, enter an “N”. Note that in AAF, RRF and SCD cases the system defaults to “N”. If a “Y” is entered, the system requires the entry of Authorized Representative/PACE/CAP data prior to the disposition of the application (See [EIS2240](#), Authorized Representative).

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(III.F.)

2. The PF12 key on the DSS-8124 takes you to the “AUTH REP – PACE/CAP AGENCY DATA” screen where this data is entered.
3. For the Authorized Representative, required fields are the name, address, relationship code of the representative to the applicant, and the language preference of the representative. Use the existing language preference codes found in EIS 4000.

**IV. NOTICE PROCEDURES**

**A. DMA-5095/DMA-5095S – Medicaid/Work First Notice Of Inquiry**

The DMA-5095/DMA-5095S, Medicaid/Work First Notice of Inquiry, is used for documenting an inquiry interview. It notifies the individual of the reason he chose not to apply for Medicaid and his right to appeal if he believes the county dss discouraged him from applying for assistance.

Complete the notice of inquiry during the intake interview. Refer to MA-2301, Conducting A Face-to-Face Interview, for instructions on completing the DMA-5095/DMA-5095S, Medicaid/Work First Notice of Inquiry. Give the original to the individual. File a copy in the case record.

**B. Approval Notice**

1. Use the DSS-8108A/DSS-8108S, Notice of Benefits, or manual DMA-5002/DMA-5002S, Approval Notice, for notifying the a/r when:
  - a. Approving an application.
  - b. Approving a portion of a certification period and denying a portion of a certification period. This includes but is not limited to open/shut applications and an application in which a deductible is met or reserve is reduced.
  - c. Authorizing continuing eligibility with no change in benefits.
2. Always complete a manual DMA-5002/DMA-5002S, Approval Notice when:
  - a. Issuing benefits by using the DB/PML screen in EIS.
  - b. Transferring a case from Special Assistance to Medicaid.
3. Generating and Overriding the Automated DSS-8108A/DSS-8108S, Notice of Benefits

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(IV.B.3)

- a. EIS automatically generates a DSS-8108A/DSS-8108S, Notice of Benefits, for approvals and re-determinations with no change in benefits, unless the automated notice is overridden. The notice text is based upon the approval or re-determination reason code entered on the DSS-8125 screen. Refer to EIS-4000, Codes Appendix for instructions.
- b. You may choose to override the automated notice and complete a manual DMA-5002/DMA-5002S, Approval Notice. Refer to the EIS Manual for override instructions. If using a manual notice, mail or give the original to the a/r and file a copy in the case record.
- c. In the following situations, EIS will generate an automated DSS-8108A/DSS-8108S, Notice of Benefits unless overridden:
  - (1) All Parts of the Application are Approved  

One automated DSS-8108A/DSS-8108S, Notice of Benefits, is generated when approving both retroactive and ongoing assistance at the same time.
  - (2) One Part Application-Partial Approval/Partial Denial  

To generate an automated notice, enter the appropriate approval code for the portion of the certification period that is approved. Use the secondary notice code or the notice text feature for the portion of the certification period that is denied.
  - (3) Two Part Application - One Part Approved, One Part Pended  

To generate an automated notice, enter the approval code with the correct message for the portion of the application that is approved. Use the notice text feature to provide information for the automated notice on the status of the portion of the application that is pended.

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(4) Two Part Application - One Part Approved, One Part Denied

A DSS-8108A/DSS-8108S, Notice of Benefits, is generated for the part of the application that is approved and a [DSS-8109A/DSS-8109S](#), Notice of Benefits Denied or Withdrawn, is generated for the part of the application that is denied.

You may override the automated notice DSS-8108A/8108S, Notice of Benefits, and send one manual notice [DMA-5002/DMA-5002S](#), Approval Notice, to approve one part and deny the other part.

(5) Two Part Application - Partial Approval/Partial Denial

An automated DSS-8108/DSS-8108S, Notice of Benefits, is not appropriate in this situation. Manually complete a separate DMA-5002/DMA-5002S, Approval Notice for each part of the application when approving a retroactive certification period and an ongoing certification period at the same time and there is a period of ineligibility in each certification period and the reasons for the ineligibility are different.

**C. DSS-8109/DSS-8109S – Notice of Benefits Denied or Withdrawn**

1. The [DSS-8109/DSS-8109S](#), Notice of Benefits Denied or Withdrawn, is used for denying or withdrawing an application. It notifies the applicant of the denial/withdrawal action, the reason for the denial/withdrawal and his right to appeal if he disagrees with the denial/withdrawal.
2. EIS automatically generates a [DSS-8109/DSS-8109S](#), Notice of Benefits Denied or Withdrawn, unless the automated notice is overridden. Refer to [EIS-2150](#), Denying an Application, for override instructions.
3. When the automated notice is overridden, document the reason for the override in the case record and manually complete the DSS-8109/DSS-8109S, Notice of Benefits Denied or Withdrawn. **See Manual Notice instructions below.**

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**4. Automated Notice Instructions**

a. Denials

- (1) Indicate on the notice the type of assistance being denied and the reason for the denial.
- (2) Always use the appropriate denial code when denying an application. Avoid the use of "other" codes wherever possible. It is important that the text on notices clearly explain the reason for the denial to the applicant.
- (3) If you find a situation for which there is no appropriate denial code, please notify the EIS Unit so that needed codes can be developed.

b. Withdrawals

- (1) Indicate on the notice the type of assistance being withdrawn and that the application is being withdrawn at the applicant's verbal or written request, whichever is appropriate.
- (2) Carefully document in the record the reason for the applicant's withdrawal and that all alternatives to withdrawal were explained.

Refer to MA-2304, Processing the Application for specific documentation instructions for withdrawals.

c. Enter the policy manual section that supports the denial or withdrawal.

d. Complete WHEN TO ASK FOR A HEARING. Begin counting the 60 calendar days on the day following the date of the notice. If the 60<sup>th</sup> day falls on a non-workday, the applicant has until the end of the next workday to request a hearing.

e. Mail or give the original to the applicant. File a copy in the case record.

**5. Manual Notice Instructions**

a. General Requirements

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- (1) If the notice is handwritten, the writing must be legible.
- (2) Use language that is clear and understandable.
- (3) Write out all dates completely, including month, day and year.  
Example: September, 15, 2011.
- (4) Keep a copy of each manual notice in the case record.

b. Instructions for Completing the [DSS-8109/DSS-8109S](#).

- (1) Enter the name of your county, the date the notice is mailed and the recipient or casehead/payee's name and mailing address.
- (2) Enter the aid program/category for which the person applied in the space following the words "Your application for". If this is an application for Work First and both Work First and Medicaid are denied or withdrawn, write "Work First and Medicaid".
- (3) Enter "denied" or "withdrawn" in the second space.
- (4) Explain exactly why the application is denied or withdrawn, using language that is easy to understand. Refer to the text for the automated codes for appropriate wording.
- (5) Check the "If this box is checked" box if a separate evaluation (spin off) is being done for Medicaid.

All denied WFFA applications must be evaluated for Medicaid unless the reason for denial is one of the exceptions listed in MA-3410, Terminations and Deletions.

- (6) After "The State regulations requiring this action are found in," cite the manual reference from the appropriate manual that supports the denial or withdrawal. It is not necessary to cite the actual text.
- (7) Enter the deadline date for the applicant to request a hearing. The deadline date is the 60<sup>th</sup> calendar day after the date the notice is mailed. Begin counting the 60 calendar days on the day following the date of the notice. If the 60<sup>th</sup> day falls on a non-workday, the applicant has until the end of the next workday to request a hearing.

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- (8) Enter the caseworker name (typed or written legibly), the phone number and the agency mailing address.
- (9) Use the “For Office Use Only” area to enter information to identify the applicant’s:
  - County case number, and
  - EIS case id number, and
  - Aid program/category.
- (10) Mail or give the original to the applicant. File a copy in the case record.
- (11) Mail a copy to all authorized representatives.
- (12) Refer to [DSS-8109/DSS-8109S](#), Notice of Benefits Denied or Withdrawn and instructions for completion.

**D. DSS-8110/DSS-8110S – Notice of Change in Benefits**

The [DSS-8110/DSS-8110S](#), Notice of Change in Benefits, is used to notify the recipient when benefits are changed, reduced or terminated. It notifies the recipient of what the change is, when it will take place, the reason for the change, and of his right to appeal if he disagrees with the case action. The manual DSS-8110/DSS-8110S, Notice of Change in Benefits, may be used for timely or adequate case actions.

EIS automatically generates a DSS-8110/DSS-8110S, Notice of Change in Benefits, unless the automated notice is overridden. Refer to the EIS Manual for override instructions.

1. Adequate Notice

The recipient must be informed in writing of a change in benefits prior to the change. The effective date of an adequate notice is the day that it is mailed.

Use an adequate notice only in the following situations:

- a. The change is beneficial to the recipient.
- b. A recipient dies.
- c. A recipient is admitted to a public institution and no longer qualifies for assistance.

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- d. A recipient signs and dates a written statement to have his assistance terminated or reduced. The request must specifically request Medicaid termination. The record must include documentation that the recipient understood he may still be eligible for Medicaid and chose not to continue.
- e. A recipient begins to receive nursing home level of care in a nursing facility or swing/inappropriate level of care bed in a hospital. Refer to MA-2270, Long Term Care Need and Budgeting for procedures.
- f. The patient's physician prescribes a change in level of medical care, i.e., skilled or intermediate nursing care or long-term hospitalization.
- g. A recipient cannot be located and procedures in MA-2304, Processing The Application, were followed.
- h. A recipient begins to receive assistance in another state with no break in benefits.
- i. A North Carolina Health Choice recipient becomes eligible for Medicaid.

2. Timely Notice

Use a timely notice any time assistance is reduced or terminated, except for the situations described in III.D.1.

The recipient must be informed in writing of the intended change or termination prior to taking the action. Do not reduce or terminate benefits until 10 workdays following the date the notice is mailed. **Key the change/termination on the first workday following expiration of the 10 day notice.**

3. When You Must Use A Manual DSS-8110/DSS-8110S, Notice of Change in Benefits

Do not use an automated DSS-8110/DSS-8110S, Notice of Change in Benefits in the following situations. Complete and mail a manual notice when:

- a. Any benefits are issued using the DB/PML screen, or a change in PML or deductible balance is posted in EIS.
- b. A case action involves a program transfer from Special Assistance to Medicaid.

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4. Generating and Overriding the Automated DSS-8110/DSS-8110S, Notice of Change in Benefits
  - a. When you make a change to reduce or terminate benefits by entering a timely reason code on the DSS-8125 screen, EIS produces and mails an automated DSS-8110/DSS8110S, Notice of Change in Benefits. The word "TIMELY" is printed at the top of the automated notice.
  - b. When you make a change to reduce or terminate benefits by entering an adequate reason code, EIS produces and mails an automated DSS-8110/DSS-8110S, Notice of Change in Benefits. The word "ADEQUATE" is printed at the top of the automated notice.
  - c. When the DSS-8125 screen is correctly entered following instructions in the EIS Manual, the automated notice is produced and mailed the next State work day after the DSS-8125 form processes.
  - d. You may choose to override an automated timely or adequate notice and complete a manual notice. If using a manual notice, send the original to the a/r and file a copy in the case record. Refer to [DSS-8110/DSS-8110S, Notice of Change in Benefits](#), for a sample of the manual notice and instructions for completing it.
5. Notice Texts
  - a. Refer to the [EIS-4000, Codes Appendix](#), for the notice text for automated notices. The texts are tabled in EIS and are printed on the automated notice based upon the change or termination reason code.
  - b. Use the appropriate change or termination reason code based on the reason for the change. If an automated notice text does not exist which covers the change or termination, use the change reason "other" (02 for timely and 50 for adequate). If you use "other," use the Notice Text feature to provide the appropriate message for the automated notice. Or, you may choose to complete a manual notice.
  - c. When using a manual notice, use text that clearly explains the reason for the change. Avoid the use of "other" codes wherever possible. It is important that the text on notices clearly explain the reason for the change to the recipient.
  - d. If you find a situation for which there is no appropriate code, please notify the EIS Unit so that needed codes can be developed.

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6. Manual Notice Texts

a. General Requirements

- (1) If the notice is handwritten, the writing must be legible.
- (2) Use language that is clear and understandable.
- (3) Write out all dates completely, including month, date and year. For example, write September 15, 2011.
- (4) Keep a legible copy of each manual notice in the case record.

b. Instructions for Completing the [DSS-8110/DSS-8110S](#).

- (1) Enter the name of your county, the date the notice is mailed, and the recipient or casehead/payee's name and mailing address.
- (2) "What The Change Is:" Explain exactly what the change is using language that is easy to understand. Refer to the text for the automated codes for appropriate wording.

For Work First, you must always include a statement about what will happen to Medicaid (such as "Medicaid will continue," "Medicaid will also stop," or "Your Medicaid will be evaluated. You will receive a separate notice about Medicaid.").

- (3) "Why the Change Will Be Made:" Explain clearly why the change is being made.
  - (a) "Your family's countable income has increased."
  - (b) "Your children no longer live with you."
  - (c) "Your assets exceed the limit."
  - (d) "Your medical expenses do not indicate that you will meet your deductible within your certification period."
  - (e) "Your income increased."

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- (4) "When The Change Will Happen:" Write in the date the change in benefits takes place. (This is not the date the caseworker takes action to make the change in EIS.)

The effective date for a change in benefits is the first day of the month. The effective date for a termination of benefits is the last day of the month.

- (5) If the recipient is on Medicare buy-in, write on this line whether payment of the Medicare premium will "continue" or "stop." If the recipient is not on Medicare, write in a notation to indicate "not applicable."
- (6) "State Regulations:" Cite the manual reference from the appropriate manual that supports the denial or withdrawal. It is not necessary to cite the actual text.
- (7) "Hearing Rights:" Use this section to advise recipients that they have a right to a hearing if they disagree with the decision and whether they can receive continued benefits if they request a hearing.
- (8) Adequate Notice: Check the first block if the notice is an adequate notice. The recipient does not have a right to continued benefits.
- (9) Timely Notice: Check the second block if the notice is a timely notice. The recipient's benefits continue until the first hearing decision is rendered if the hearing is requested by the deadline, unless he waives this right. Enter the deadline date for requesting the hearing and continuing benefits, which is the 10th workday from the date the notice is mailed. Begin counting the 10 workdays on the day following the date the notice is mailed.
- Enter the deadline date for the recipient to request a hearing, which is the 60th calendar day after the date the notice is mailed. Begin counting the 60 calendar days on the day following the date the notice is mailed. If the 60th day falls on a non-work day, the recipient has until the end of the next workday to request a hearing.
- (10) Enter the caseworker name (typed or written legibly), the phone number and the agency mailing address.

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- (11) **“FOR OFFICE USE ONLY” Use this area to enter information to identify the recipient's:**

**County case number,  
EIS case id number, and  
Aid program/category.**

7. Automated Notice Effective Dates

a. Timely Notice

- (1) When you enter a timely reason code in EIS, the date of the automated timely notice is the first State workday after the DSS-8125 screen successfully processes in EIS. The notice is also mailed on this date.

Example: The DSS-8125 screen is entered August 2<sup>nd</sup> (Friday). The notice is dated and mailed on August 5<sup>th</sup> (Monday).

- (2) The 10-workday timely notice period begins the first State workday after the day the notice is mailed.

Example: The DSS-8125, screen is entered August 2<sup>nd</sup> (Friday). The notice is dated August 5<sup>th</sup> (Monday). The 10-day period begins on August 6<sup>th</sup>. Therefore the 10<sup>th</sup> workday is August 19<sup>th</sup> (Monday).

- (3) The change in the case will process on the night of the first State workday immediately following the 10-workday period unless the action is rescinded or deleted. See instructions in III.D.6.e. and III.D.6.f., for rescinding or deleting a timely action.

In the example above, EIS is updated with the changed information on August 20<sup>th</sup> (Tuesday night), unless the action is rescinded or deleted.

b. Timely Notice With Override of Automated Notice

When you enter a timely reason code and you override the automated notice by keying "Y", EIS will count 10 workdays and update the system on the same schedule as it does when the notice is not overridden. Overriding the automated notice does not prevent EIS from processing the timely action on the night of the first State workday following the 10 workday period.

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c. Adequate Notice

When you enter an adequate reason code, the date of the automated adequate notice is the first State workday after the DSS-8125 screen processes. The notice is also mailed on this date. EIS is updated with the changed information the night the change is entered.

When you enter an adequate reason code and you override the automated notice by keying "Y", EIS will process the action that night. Therefore, the manual adequate notice must be dated and mailed on the same day the action is entered in EIS.

d. In certain case situations, you may choose to use a combination of timely and adequate actions.

(1) Complete and mail a manual timely notice to the recipient. On the workday following the 10<sup>th</sup> workday of the manual notice, enter the DSS-8125 with an adequate reason code and override the automated notice. The recipient has already been notified; therefore, another notice is not required.

OR

(2) On the workday before the manual timely notice is mailed, enter the correct timely reason code and override the automated notice. If the recipient comes in during the 10-day period and establishes ongoing eligibility with no change, delete the timely action. The timely action will not occur in EIS until after the 10<sup>th</sup> workday even if you override the notice.

e. Deleting Timely Action

If you use a timely reason code and the recipient responds within the 10 workdays, and eligibility continues with no change in benefits, delete the timely action. Refer to the EIS Manual for instructions on deleting the DSS-8125.

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(IV.D.7.)

f. Rescinding Timely Action

- (1) If you use a timely reason code and the recipient responds within the 10 workdays, and eligibility continues with a change in benefits, rescind the timely action. This means that EIS will not process the pending timely action; it will be replaced by the new action.
- (2) If a timely action is pending and you enter a new action in EIS that produces a notice, EIS will rescind the pending timely action. This is true for any new action, whether timely or adequate (requires reason code). Even if you override the notice on the second action, the new action will rescind a pending timely action. This also includes continuation of benefits after a review, terminations, deletions, an increase in the PML or a change in status from "Authorized" to "Deductible" or "Deductible" to "Authorized".

Example: A timely action was keyed in EIS on Friday, May 15<sup>th</sup>. The notice was mailed Monday, May 18<sup>th</sup>. The termination will process on the night of Tuesday, June 2<sup>nd</sup>. If you key another change action (timely or adequate) during the 10-workday period of May 19<sup>th</sup> through June 1<sup>st</sup>, the first action is rescinded.

- (3) During the 10-workday period of a timely notice, adequate changes may occur which would have the same effective date as the timely negative action. If the recipient responds to the timely notice by successfully establishing continuing eligibility but there is also an adequate change to the case:
  - (a) Enter a new DSS-8125 screen with the adequate change reason and the changes to the case. The adequate change notice may be automated or manual.
  - (b) The adequate change will rescind the pending timely action. If that action should still take place, enter another DSS-8125, screen. Use an adequate change code and enter "Y" in notice override. Enter this DSS-8125, screen on the first workday following the day the timely change processes (the 11<sup>th</sup> workday).
  - (c) Another timely notice is not required because the first one has already been produced and mailed.

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(IV. D. 7.f.(3))

- (d) If no notice is produced because there is no change code or the notice is overridden, the pending timely action will not be rescinded. It will take place on the eleventh workday. A notice is not produced when demographic information, such as the address, is changed.

g. Demographic Changes During the Timely Notice Period

You can enter in EIS case changes that do not affect the type, amount or duration of assistance while the timely action is pending, except on the last day of the 10-workday period. These include address changes and any changes to individual data other than a deletion, add-individual, or date of death.

- h. If the DSS-8125, screen is entered too late in the month (after pull cutoff) to make the termination or change effective the next calendar month, EIS automatically changes the effective date.

Example: DSS-8125, screen showing a termination effective date of March 31<sup>st</sup> and a timely reason code is entered on March 14<sup>th</sup>. The day after the 10<sup>th</sup> workday is March 30<sup>th</sup>. Pull cutoff is March 22<sup>nd</sup>. Because the action effective day falls after pull cutoff, EIS will change the termination effective date to April 30<sup>th</sup>.

8. Schedules of Timely Actions Pending in EIS

a. Automated Timely Notice Schedule When EIS Issues A Notice

FRI Mar 13	MON Mar 16	TUES Mar 17	MON Mar 30	TUES Mar 31	Night of March 31
Workday #1	Workday #2	Workday #3	Workday #12	Workday #13	Night of Workday #13
DSS-8125 entered	Notice is mailed	Notice day #1	Notice day #10 - 10 days expires	Notice day #11  5:00 deadline to delete or rescind the action	EIS updated

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(IV.D.8.)

b. Processing Schedule When You Override A Notice

FRI Mar 13	MON Mar 16	FRI Mar 27	MON Mar 30	Night of March 30
Workday #1	Workday #2	Workday #10	Workday #12	Night of Workday #12
DSS-8125 entered with override	Notice day #1	Notice day #10 - 10 days expires	Notice day #11	EIS updated
IMC mails notice			5:00 deadline to delete or rescind the action	

**E. Additional Message Capability**

There are some situations with Medicaid approvals and changes when part of an eligibility period is affected or only some of the individuals involved will receive the same benefits. For these situations, EIS has two additional notice message features.

1. Secondary Notice Codes

Use a secondary notice code only when an application is approved. Refer to the EIS Manual for Secondary Approval Code Table. You may use only one secondary code with an approval code.

Example: Mr. Brown applied retroactively for August, September, and October. August and October are approved but September is denied because Mr. Brown was over the reserve limit for September. Use the approval code for the automated notice. Use the secondary notice code for a retroactive month denied on the basis of excess reserve. The following message will print on the notice: "Medicaid was denied for other months for which you applied because you were over the reserve limit."

2. Free Form Text Capability (Notice Text)

If the case situation calls for a message for which there is no reason, you may use the Notice Text capability of EIS rather than send a manual notice. Refer to the EIS Manual for detailed instructions on the use of this function and for a copy of the recommended Supplemental Notice Information form.

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(IV.E.2.)

a. Approvals

When an appropriate secondary approval code is not available, you may use Notice Text. The automated notice will include the message from the approval code and the Notice Text message.

b. Changes and Terminations

If the change or termination reason is "other", you must supply the text of the notice by using the Notice Text capability. The notice will not be generated if the text is not entered.

**F. Automated Notice Register**

EIS does not provide counties with a copy of each individual notice it generates and mails. Instead, EIS produces a register each night that lists each adequate, timely and approval notice that it generated. It also lists cases for which the notice was overridden, deleted, or rescinded. The notice register is mailed to the county the next workday. The register is also available in XPTR. Refer to EIS 2304, Notice Register Report and EIS 1061, XPTR Report Distribution System.

**V. HEARING PROCESS**

**A. Purpose**

1. Local

The local hearing allows the county dss agency to explain the action in question and gives the applicant/recipient an opportunity to explain why he feels that action should not take place.

2. State

The State hearing safeguards the interest of the a/r and assures fair and equitable administration of assistance programs.

**B. Applicant's/Recipient's Rights**

1. The applicant/recipient has the right to appeal when:

- a. The county dss denies an applicant the opportunity to make an application on the day he first appears at the agency and wishes to apply.

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(V.B.1.)

- b. The individual alleges he was discouraged for any reason from applying for assistance. See MA-2300, Initial Contact, for the definition and examples of discouragement.
- c. The individual alleges the county dss improperly withdrew his application. See MA-2304, Processing The Application, for the definition of improper withdrawals.
- d. The individual alleges the county dss improperly denied his application. See MA-2304, Processing The Application, for the definition of improper denials.
- e. Assistance is approved, denied, modified, or terminated.

Do not conduct a hearing when either State or federal law requires automatic adjustments for classes of recipients, unless the reason for the hearing is incorrect computation or there is a factual issue regarding whether the change applies.

- f. The applicant/recipient disagrees with the amount of his deductible or patient monthly liability.
- g. The county dss fails to act within the required time standards.
- h. The county dss fails to act promptly on a request for a review of the case situation.
- i. The applicant/recipient disagrees with the determination of:
  - (1) The community spouse income allowance, or

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(V.B.1.i.)

- (2) The amount of monthly income available to the community spouse, or
    - (3) The computation of the community spouse resource allowance, or
    - (4) The resources determined available to the institutionalized spouse after deducting the community spouse resource allowance.
  - j. The recipient disagrees with the establishment of an overpayment. See MA-2900, Recipient Fraud and Abuse Policy and Procedures.
2. The applicant/recipient may request the hearing verbally or in writing.
3. The applicant/recipient must request a hearing within 60 calendar days from the date the notice of action is mailed or given, unless he can show good cause for a later request. If good cause exists, the request must be no later than 90 days from the date of the notice of action.
  - a. For appeals based on allegation of discouragement, improper withdrawal, or improper denial, the time limit for requesting a hearing shall be 60 days (or 90 days with good cause) from the date the applicant became aware or should have known that incorrect or incomplete information given by the county dss caused him not to apply, caused him to withdraw his application, or that the denial was improper.
  - b. Good cause is defined as:
    - (1) Failure of the a/r to receive the notice of action, or
    - (2) Extended hospitalization of the a/r, spouse, child, or parent of the a/r, or
    - (3) Failure of a representative acting on the a/r's behalf to meet required time frames, or
    - (4) Illness resulting in incapacity, incompetence, or unconsciousness of the a/r and there is no representative acting on his behalf, or
    - (5) Death of the a/r or his representative, or
    - (6) Failure of the county dss to provide sufficient or correct information regarding appeal rights.

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(V.B.3.)

c. The a/r must provide evidence of good cause, which includes but is not limited to:

- (1) Physician's written statement, or
- (2) Hospital bill, or
- (3) Written statement of a/r, his representative, or other individual knowledgeable of situation.

4. In cases involving issues other than disability, the applicant/recipient has the right to request a State hearing only after a local hearing has been held and a decision has been rendered.
5. In cases involving a question of disability, an applicant/recipient has the right to request a State hearing even when the disability decision is an SSA/SSI adoption.  
This includes appeals requested on ex parte reviews when SSA denied for no longer being disabled and the recipient is ineligible for any other Medicaid programs, yet the recipient claims he is still disabled.

Within 5 calendar days of the request for a hearing, the county director or his designee must forward the request to the Chief Hearing Officer to schedule a State hearing. A State hearing officer will make a determination if certain criteria apply to the recipient.

6. Right to Continued Benefits (Not Applicable to NC Health Choice)

A recipient whose benefits are changed or reduced may be entitled to continued benefits while awaiting a hearing decision. Continuation of benefits applies only to recipients. It does not apply to applicants who are denied assistance, because there are no benefits to continue.

a. Recipients Who Receive Timely Notice

- (1) If a recipient appeals a reduction or termination of benefits on or before the effective date of the change (10 workdays after the notice is mailed or given to the recipient), he has the right to continued benefits until the end of the month in which the local hearing decision is rendered, except when the reduction or termination involves a disability determination or the recipient waives his right to continued benefits.

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(V. B. 6.a.(1))

If the reduction or termination involves a disability determination, the recipient who meets all other eligibility factors has the right to continued benefits until the end of the month in which the:

- (a) State hearing decision is rendered, or
  - (b) Social Security Administration Appeals Council's final decision is rendered with no right to further review, whichever occurs later.
- (2) The recipient is not entitled to continued benefits if the appeal is requested after the 10-workday period.
- (3) When the recipient requests the hearing, advise him that:
- (a) If the reduction or termination of benefits is affirmed by the local or state hearings officer, he may be required to repay the benefits he received while awaiting a decision, or
  - (b) If the appeal involves a disability determination and the Social Security Administration affirms the reduction or termination of benefits, he will not be required to repay the benefits. This applies even if a state appeal also affirms the county's action to terminate,
- And
- (c) He has the right to choose not to continue to receive benefits.
- (4) In some cases, a hearing decision upholding the county's action will be rendered prior to the termination of benefits. In these situations, no additional action is necessary.
- (a) If benefits must continue for an additional period, administratively reopen the Medicaid case for one month at a time until the hearing decision is rendered if the appeal is related to a non-disability issue.
  - (b) Refer to MA-2525, Disability, for continuation of benefits procedures when the appeal involves a disability determination.

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(V. B.6.)

b. Recipients Who Receive Adequate Notice

Recipients who receive adequate notice and appeal do not have the right to continued benefits.

7. The a/r must request a State hearing within 15 calendar days of the mailing of the local hearing decision, unless he can show good cause for a later request as outlined in IV.B.3.
8. The a/r has the right to be represented at the hearing by the person of his choice, including an attorney obtained at his expense.
9. If at any point, the a/r does not exercise his right to a hearing or the right to continued benefits, he still has the right to reapply.

**C. Request for a Hearing**

1. Local

Immediately notify the appropriate county staff when an a/r requests a local hearing. Inform the a/r that the local hearing officer will be contacting him regarding his request and that the local hearing must be held not more than 5 calendar days after the request is received.

2. State

- a. Submit the DSS-1473, Request for State Appeal, to the Chief Hearing Officer, Hearing and Appeals Section, Division of Social Services:
  - (1) On the day the a/r requests a State hearing that does not involve a question of disability/incapacity.
  - (2) Within 5 calendar days of the date the a/r requests a State hearing that involves a question of disability/incapacity.
- b. Attach a copy of the local hearing decision, if applicable.
- c. Attach to the DSS-1473, Request for State Appeal all medical records dated within the last 12 months when the denial or termination of assistance is due to disability. If older medical information is needed, the State hearing officer, following a review of the more recent information, will request it.

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(V .C. 2.)

- d. If there has been no response from a State hearing officer within 60 days of the date the DSS-1473, Request for State Appeal, was sent, the county must contact DSS Hearing and Appeals to follow up on the status of the request. DSS Hearing and Appeals can be reached at (919) 855-3260.

3. **Request for Hearing when Applicant is Deceased**

If the applicant dies during the application process, an Authorized Representative may request the hearing. In the absence of an Authorized Representative, a family member may request the hearing. If there is no family member identified in the file, a hospital where the decedent received services during the ongoing or retroactive period covered by the application may request the hearing.

#### **D. Scheduling**

1. The local or State hearing officer assigned to the hearing will give reasonable notice to the county and the a/r of the time and place of the hearing.
2. The a/r may request and is entitled to receive a postponement of the scheduled hearing if good cause exists.

- a. Local

If the a/r has good cause, the local hearing may be delayed for up to 10 more calendar days. A local appeal hearing may never be held more than 15 calendar days after the request for a hearing is received.

- b. State

The postponement of a State hearing may not exceed 30 calendar days from the date the hearing was originally scheduled.

- c. The a/r has good cause to postpone the hearing when:

- (1) There is a death in the a/r's family.
- (2) The a/r or someone in his family is ill.
- (3) The a/r is unable to obtain representation.
- (4) The a/r's representative has a conflict with the scheduled date.
- (5) The a/r is unable to obtain transportation.

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(V.D.2.c.)

- (6) The hearing officer determines that the hearing should be delayed for some other reason.

**E. Place**

Hold the local and/or State hearing in the county dss office unless the a/r is bedfast or has great difficulty moving. In such cases, the hearing may be held where the a/r lives.

**F. Seeing the Record**

Prior to and during the hearing, the appellant or his personal representative may examine the contents of his case file together with portions of other public assistance or social services case files that pertain to the appeal. He may also examine all other documents and records to be used at the hearing. The appellant or his representative may obtain copies of these materials without charge.

**G. Summary**

1. The IMC must prepare an original and two copies of the hearing summary discussing the county dss action and the reasons for that action.
2. Cite the specific regulations substantiating the action.
3. Attach to the summary copies of pertinent documents.
4. Give the original to the hearing officer. Give one copy to the a/r and file a copy in the eligibility record.

**H. Attendance**

Attendance at the hearing is limited to the a/r, his representative, appropriate representatives of the county dss and/or State, and any witnesses that the a/r or the county dss wish to call upon for testimony.

**I. Conducting the Hearing**

1. Local  
  
Refer to the “Local Appeal Hearing Officer's Handbook.”
  - a. The county director or his designee presides at the local hearing and ensures that the oath or affirmation is administered to all participants.

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(V.I.1.a.)

- (1) The designee can include another county employee, a board member, or an employee of a social services agency in another county.
    - (2) The local hearing officer must not have been directly involved in the initial decision that resulted in the appeal.
  - b. There is no requirement that the local hearing be recorded. However, a written summary of the hearing must be maintained in the case file.
2. State
  - a. A State hearing officer from the Division of Social Services presides at the hearing and administers the oath or affirmation to all participants.
  - b. The State hearing officer will also record the hearing. No transcript will be prepared unless a petition to Superior Court is filed.
3. The a/r and the county dss may be represented by attorneys or other individuals obtained at their expense.
4. The county dss and the a/r must each name someone to present their testimony and to call as witnesses. Any person testifying must be sworn in.
5. The county dss' representative must read the summary and explain the county's action, or call upon someone to do so. He may call witnesses, one at a time. The hearing officer may question witnesses during their testimony. When the county's testimony has ended, the a/r or his representative may question the county's witnesses or representative.
6. The a/r or his representative may then explain why he feels the county dss' action should not be implemented. He may call witnesses, one at time. The hearing officer may question witnesses during testimony. When the a/r's testimony has ended, the dss representative may question the a/r, witnesses, or representative.
7. Representatives for the county dss and the a/r may present closing statements summarizing their view of the situation in question.

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(V.)

**J. Decision**

1. Local

- a. The local hearing officer must make a decision on the case, based on appropriate regulations and evidence presented at the hearing. Those factors must be cited in a written statement of decision.
- b. The written statement of decision must be sent to the a/r by certified mail within 5 calendar days of the date of the local hearing. Retain a copy in the case file.

(1) Applications

The county dss must implement a local appeal decision within 5 workdays of the date the decision is rendered.

(2) Terminated/Modified Cases

The county dss must implement a local appeal decision within 14 calendar days of the date the decision is rendered.

2. State

- a. The State hearing officer must render a decision not more than 90 calendar days from the date of the request for the hearing unless the hearing was delayed at the a/r's request.

If the hearing is delayed at the a/r's request, the hearing decision can only be delayed for the length of time allowed for the a/r's delay.

If a State hearing has been held and the county has not received a response after 60 days, the worker needs to contact DSS Hearing and Appeals to check the status of the decision.

- b. The hearing officer will prepare a tentative decision on the DSS-1894, Notice of Decision, which will be sent to the a/r by certified mail. A copy will also be mailed to the county dss. The tentative hearing decision becomes final 10 calendar days from the date of the DSS-1894, Notice of Decision

(1) Applications

The county dss must implement a State appeal decision within 5 workdays of the date the DSS-1894, Notice Of Decision, becomes final.

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(V.J.2.b.)

(2) Terminated/Modified Cases

The county dss must implement a State appeal decision within 14 calendar days of the date the DSS-1894, Notice of Decision, becomes final.

- c. The county dss or the a/r may present oral and/or written arguments, for or against the Notice Of Decision, no later than 10 calendar days from the date of the notice. Both must contact the chief hearing officer to present arguments. No new evidence will be accepted at this level of the appeal process.
- d. If no written argument or request for oral argument is made within 10 calendar days of the tentative decision, the tentative hearing decision becomes final.
- e. If the party that requested oral argument fails to appear at the hearing for oral argument, the tentative decision becomes final.

3. Remanded Appeals

A remanded appeal decision is a written instruction to the county dss to reconsider the county's determination of eligibility based upon new evidence that was presented at the hearing or upon policy that may not have been considered. It is not a reversal of the county's action. Instead the hearing officer remands the case to the county dss for reconsideration.

Once the reconsideration is completed, the county's determination of eligibility may or may not be the same as the original determination.

- 4. Refer to MA-2304, Processing the Application, for instructions on re-opening and processing applications and terminated cases due to local/state appeal reversals or remanded appeal decisions.
- 5. If eligibility is approved for any period for which the time limit for filing claims has expired, you must submit a request for an override of the time limit. Refer to MA-2395, Corrective Actions and Responsibility for Errors, for override instructions.

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(V.)

**K. Recovery**

1. Local

If a reduction or termination of assistance is affirmed, any benefits received during the time of the local appeal may be subject to recovery.

2. State

If a reduction or termination of assistance is affirmed, any benefits received during the time of the State appeal may be subject to recovery unless the issue involves a disability determination.

- a. For State appeals involving a disability determination, any benefits received during the time of the state appeal may be subject to recovery unless the recipient has also filed a timely appeal of the Social Security/SSI denial or termination.
- b. If the recipient does not file a timely appeal of the Social Security/SSI denial or termination, any benefits received during the time of the State appeal may be subject to recovery.

**L. Further Appeal**

1. Local

If the a/r is not satisfied with the local hearing decision, he may request a State hearing through the county dss. The State hearing request must be made within 15 calendar days of the mailing of the local hearing decision or within 90 days of the date of the original notice of action, if good cause as defined in IV.B.3., exists.

2. State

a. Applicant/Recipient

If the a/r is not satisfied with the final decision following the State hearing, he may file a petition for judicial review in Superior Court within 30 calendar days of the receipt of that decision. For appeals filed after 30 calendar days, a Superior Court judge may issue an order permitting a review if the judge believes good cause exists for the delay in filing.

b. County DSS and State

Neither the county dss nor the State may appeal a hearing decision to Superior Court.