

PLEASE READ THIS IMPORTANT NOTICE ABOUT YOUR MEDICAID OR NC HEALTH CHOICE

APPROVAL NOTICE

NORTH CAROLINA _____ County Department of Social Services

Date Mailed: _____

APPROVALS

- The application for _____ for _____ is approved.
- Eligibility for _____ for _____ continues from _____ to _____.
- Medicaid is **approved** starting _____ and ending _____.
- Medicaid covers all necessary medical services.
- Medicaid pays only for services related to pregnancy and for conditions that may complicate the pregnancy.
- Medicaid pays only for limited services related to Family Planning. Your partner may be potentially eligible also.
- Retroactive Medicaid coverage is approved for the period(s) of _____, _____, _____.
- NC Health Choice for Children is **approved** starting _____ and ending _____.

If you receive Medicare, Medicare is responsible for your prescriptions.

The State rules used to make this decision are in _____ of the Family and Children's Medicaid Manual which says that: _____

DENIALS

- Medicaid NC Health Choice

is denied from _____ to _____ because: _____

The State rules used to make this decision are in _____ of the Family and Children's Medicaid Manual which says that: _____

HEARING RIGHTS: If you disagree with this decision, you have a right to a hearing to review this decision. Call your worker at the number below within 60 days to ask for a hearing. The 60th day is _____. If you do not ask for a hearing by this date, you cannot have a hearing unless you have a good reason for missing this deadline. You may reapply for benefits at any time. To protect your rights, you may BOTH reapply AND ask for a hearing.

FREE LEGAL HELP: Free Legal Aid may be available to you. Contact your nearest Legal Aid or Legal Services office, or call 1-877-694-2464 toll free.

Caseworker Name and Phone Number

Address _____

FOR OFFICE USE ONLY:
County Case # _____
Case ID # _____
Aid Program/Category _____

**** YOU WILL RECEIVE A RE-ENROLLMENT NOTICE WHEN IT IS TIME TO REVIEW YOUR ELIGIBILITY FOR MEDICAID OR NC HEALTH CHOICE. IT IS IMPORTANT TO RE-ENROLL TO CONTINUE YOUR HEALTH COVERAGE.**

PLEASE CONTINUE READING FOR IMPORTANT INFORMATION ABOUT YOUR RIGHT TO A HEARING.



**Is there a problem?
You can ask for a hearing.**

If you think we are wrong or you have new information, you have the right to a hearing. You must ask for this hearing within 60 days (or 90 days if you have a good reason for delay). This hearing is a meeting to review your case and give you the correct benefits if it was wrong.

Call or write your caseworker to ask for a hearing. A local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed, for good reasons, for as much as 10 calendar days. Then, if you think the decision in the local hearing is wrong, call or write your caseworker **WITHIN 15 DAYS** to ask for a second hearing. The second hearing is before a state hearing official.

If you are requesting a hearing about disability, call or write your caseworker to ask for a hearing. There is no local hearing. A state hearing officer holds the disability hearing.

Did you know you have the right to be represented?

You may have someone speak for you at your hearing, such as a relative or a paralegal or attorney obtained at your expense. **Free legal services may be available in your community.** Contact your nearest Legal Aid or Legal Services office, or call **1-877-694-2464** toll free.

If you have additional questions or concerns, contact your caseworker for information, or call the CARE-LINE, Information and Referral Service, toll free at 1-800-662-7030. If you live in the Raleigh area, call 919-855-4400. TDD/Voice for the hearing impaired is also available through the CARE-LINE number. Their hours of operation are 8 am to 5 pm, Monday through Friday.

Did you know you have the right to see your record?

If you ask, your caseworker will show you (or the person speaking for you) your benefits record before your hearing. If you ask, you may also see other information to be used at the hearing. You can get free copies of this information. You may see this information again at your hearing.



Do you understand your rights?

Do you understand how to get a hearing? If you have any questions, please contact your caseworker as soon as possible.

Don't forget to report all changes to your county department of social services within 10 calendar days. If you don't know whether a change is important, ask your caseworker. If you do not truthfully report information and changes, you may be guilty of a misdemeanor or felony.

I. PURPOSE OF THE FORM

- A. Use the manual [DMA-5003/DMA-5003S](#), Approval Notice, if you do not use an automated DSS-8108A/DSS-8108S, Notice of Benefits, to approve an application or to continue benefits in any aid program/category when eligibility is established. This includes retroactive benefits.
- B. Use this form when approving a portion of a certification period and denying a portion of a certification period in any aid program/category. This includes but is not limited to open/shut applications and an application in which a deductible is met or reserve reduced.
- C. Use the manual DMA-5003/DMA-5003S to issue benefits by using the DB/PML screen in EIS.

II. GENERAL REQUIREMENTS

- A. If the notice is handwritten, the writing must be legible.
- B. Use language that is clear and understandable. Avoid the use of program jargon or abbreviations that are unclear to those outside the agency.
- C. Write out all dates completely, including month, day and year. Do not use numbers for the month. For example, write September 15, 2005, rather than 9/15/05.
- D. Manually add the following sentence to the DMA-5003 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, manually add the following sentence to the DMA-5003 approval notice that does not contain information about Medicaid Family Planning Waiver Services: “Your partner may be potentially eligible also.”

- E. Keep a legible copy of each manual notice in the case record.

III. INSTRUCTIONS FOR COMPLETING THE DMA-5003, APPROVAL NOTICE

A. APPROVALS

- 1. Enter the name of your county, the date the notice is mailed and the recipient or casehead/payee’s name and mailing address.

DMA-5003

Approval Notice

REVISED 01/01/06 – CHANGE NOTICE 02-06

(III.)

2. Check the box beside the phrase, “The application for _____ for _____ is approved:” or “Eligibility for _____ for _____ continues from _____ to _____.”
 - a. List the name of the program in the first space.
 - b. Enter recipient name in the second space.
3. Enter the beginning months of Medicaid eligibility and the ending month of Medicaid eligibility
4. Check the appropriate box indicating what Medicaid will cover and the period of coverage if retroactive.
5. If North Carolina Health Choice (NCHC) is approved, check the appropriate box and enter the beginning months of eligibility and the ending month of eligibility.

B. “The State rules used to make this decision are in”

Cite the manual reference from the appropriate manual that supports the reasons for the approval or continuation of benefits as well as retroactive coverage or open/shut applications.

IV. INSTRUCTIONS FOR COMPLETING THE [DMA-5003](#), APPROVAL NOTICE, (DENIAL SECTION)

A. DENIALS

1. Check the appropriate box for Medicaid or North Carolina Health Choice (NCHC).
2. Enter the dates of Medicaid or North Carolina Health Choice (NCHC) denial.
3. Enter the reason for the Medicaid or North Carolina Health Choice (NCHC) denial.

B. “The State rules used to make this decision are in”

Cite the manual reference from the appropriate manual that supports why the benefits are being denied.

(IV)

C. Hearing Rights

Enter the deadline date for the applicant to request a hearing. The deadline date is the 60th 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 60th day falls on a non-workday, the applicant has until the end of the next workday to request a hearing.

D. Enter the caseworker name (typed or written legibly), the phone number and the agency mailing address.

E. "For Office Use Only"

Use this area to enter information to identify the applicant's:

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