

Service Agency Name
Service Agency Address Line 1
Service Agency Address Line 2
City, State, Zip Code



*

Date & Time Printed
Case Number: XXXXXXXX

Primary Client Name
Client Address Line 1
Client Address Line 2
City, State, Zip Code

<p>Medical Assistance or MinnesotaCare Closing Notice for Unresolved Discrepancy</p>

Important: Action Needed

We sent you a Discrepancy Notice asking you to confirm or update information about you or members of your household. You did not respond within 30 days, so the people listed on this form are no longer eligible for Medical Assistance or MinnesotaCare.

You may be able to continue your Medical Assistance or MinnesotaCare if you immediately contact the agency listed above or complete the Discrepancy Response Form that we sent you. You must do this before the date that coverage ends (listed below). If you complete the form, send it to the agency listed at the top of this page. If you would like to call the agency listed above and do not know the phone number, call the DHS Member Help Desk at 651-431-2670 or 800-657-3739 for assistance.

Health Care Results

[Name] - MNSure ID Number: [MNSure ID Number]

[Closing Text Verbiage Below] - Only one of the subsequent variations will appear for each household member included on the notice.

CLOSING TEXT - MEDICAL ASSISTANCE

You no longer qualify for Medical Assistance starting [Effective Date]. The last day you can receive coverage from Medical Assistance is [Coverage End Date].

You do not qualify for Medical Assistance [Denial Reason]. [(Statute)]

CLOSING TEXT - MINNESOTACARE

You no longer qualify for [Coverage Type] starting [Effective date]. If you have [Coverage Type] coverage, the last day you can receive coverage from [Coverage Type] is [Coverage End Date].

You do not qualify for MinnesotaCare [Denial Reason]. [(Statute)]

What if I have questions about this notice?

Call us if you have questions.

- For questions about Medical Assistance, call your county or tribal agency.
- For questions about MinnesotaCare, call Healthcare Consumer Support at 800-657-3672 or 651-297-3862.
- For general questions about Medical Assistance or MinnesotaCare, call Healthcare Consumer Support at 651-431-2670 or 800-657-3739.

If you have hearing or speech disabilities, contact us using your preferred telecommunications relay service.

You can also visit us in person:

- For in-person help about Medical Assistance, go to your county or tribal agency.
- For in-person help about MinnesotaCare, go to the MinnesotaCare walk-in office. The walk-in office is on the first floor of the Elmer L. Andersen Human Services Building in St. Paul. It is next to the security desk in the lobby.

Location: Elmer L. Andersen Human Services Building
540 Cedar Street
St. Paul, MN 55101

Hours: 8:00 a.m. to 5:00 p.m., Monday–Friday

Who can help me resolve a discrepancy?

If you have Medical Assistance, your county or tribal agency has workers who can help you. If you have MinnesotaCare, you can get help from workers at Healthcare Consumer Support. The Department of Human Services (DHS) also partners with trusted organizations across the state. People from these organizations, called navigators, are trained to provide free face-to-face help. To find a navigator near you, use the MNSure Assister Directory at www.mnsure.org.

IMPORTANT APPEAL RIGHTS! READ THIS NOW!

What if I do not agree with the action taken on my health care coverage?

If you think the decision in your health care notice is wrong, you have the right to appeal. An appeal is a legal process where a human services judge holds a hearing and reviews (1) a decision by the Minnesota Department of Human Services (DHS) about MinnesotaCare coverage; or (2) a decision by a county or tribal agency about Medical Assistance coverage. You can learn more about how this works at www.dhs.state.mn.us/appeals/faqs.

How do I appeal?

You can appeal by submitting your own written request, filling out a DHS appeal form, or getting help by phone or in person. The DHS Appeals Division or your county or tribal agency can help you file your appeal.

<u>1. Internet</u>	<u>2. Phone (for information on filing an appeal)</u>	<u>3. Mail or Fax</u>	<u>4. In person</u>
<ul style="list-style-type: none">Log in to your account at www.mnsure.orgOr fill out the DHS-0033 form at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG and submit it electronically.	<ul style="list-style-type: none">Call your county or tribal agency.Or call the DHS Appeals Division at 651-431-3600.	<ul style="list-style-type: none">Mail your request to Minnesota Department of Human Services Appeals Division PO Box 64941 St. Paul, MN 55164- 0941Or fax it to 651-431-7523.	Get appeals help in person at Minnesota Department of Human Services Information Desk 444 Lafayette Road North St. Paul, MN 55155.

What can I appeal?

You can appeal any of these:

- The county or tribal agency or DHS failed to act on your request about health care coverage.
- The county or tribal agency or DHS processed your request too slowly.
- The county or tribal agency or DHS took an action you do not agree with (examples of actions: denial of Medical Assistance coverage, approval of coverage for a program you do not think you are eligible for, a change in your MinnesotaCare benefits).

When must I appeal?

If your appeal involves Medical Assistance or MinnesotaCare, you must file your appeal within **30 days** of receiving your health care notice. If you show good cause for not appealing a Medical Assistance or MinnesotaCare action within **30 days**, you may be able to appeal up to **90 days** after the date of your health care notice. See below for more important information about time limits for Medical Assistance and MinnesotaCare appeals.

* ***Important:*** An appeal decision for one household member may affect the eligibility of other household members. Household eligibility may need to be redetermined.

Will my benefits continue during my appeal?

You may be able to continue to get the same benefits you were receiving at the time you got the health care notice. But you may have to file your appeal within a certain time limit. For Medical Assistance and MinnesotaCare enrollees, we usually must send you an advance notice 10 days or more before the effective date of an action, or we may send you a notice five days before an action, depending on the situation. Your benefits will automatically continue if you file your appeal by the effective date of the action on the advance health care notice. In a few situations we may send you a notice less than five days before an action, or on the effective date of an action. Your benefits will continue if you file an appeal within 15 days from the date of that health care notice. You must pay your monthly MinnesotaCare premium to get continued coverage during your appeal. Tell DHS in writing if you do not want your benefits to continue.

Important: If you lose your appeal, you may have to pay back the benefits you got while your appeal was pending.

Important: You have the right to apply for Medical Assistance or MinnesotaCare again if your benefits stop.

What if I need a hearing right away?

You have the right to ask for an expedited (sped-up) appeal. If you need a hearing right away, tell DHS the reason when you file your appeal. To ask for a sped-up appeal for Medical Assistance or MinnesotaCare, contact the DHS Appeals Office at 800-657-3510 (outstate) or 651-431-3600 (metro).

What do I do after I file my appeal?

Gather information related to the action you are appealing that you think will prove or explain the reason you think the action was wrong.

You will get a letter telling you the date and time of the appeal hearing. Many hearings are done over the phone.

Continue to report changes (such as the start or stop of a job or changes in who lives with you) within these time frames:

- **30 days** if you have MinnesotaCare
- **10 days** if you have Medical Assistance

If you have Medical Assistance, report changes by calling your county or tribal agency. If you have MinnesotaCare, report changes by calling Healthcare Consumer Support at 800-657-3672 or 651-297-3862.

Can I get help with my appeal?

You may speak for yourself at the hearing. You may also have someone else speak for you. You can let us know that you want someone else to speak for you at the hearing when you file your appeal. If your income is below a certain limit, you may be able to get legal advice or help with your appeal from your local legal aid office.

Civil Rights Notice

CB3 HC-Medical 1-18

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- | | | | |
|-------------------|----------------------|----------------------------|---|
| ■ race | ■ creed | ■ public assistance status | ■ disability |
| ■ color | ■ religion | ■ marital status | ■ sex (including sex stereotypes and gender identity) |
| ■ national origin | ■ sexual orientation | ■ age | ■ political beliefs |

Auxiliary Aids and Services: DHS provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.

Language Assistance Services: DHS provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human services agency. You may contact any of the following three agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- | | |
|-------------------|--------------|
| ■ race | ■ age |
| ■ color | ■ disability |
| ■ national origin | ■ sex |

Contact the **OCR** directly to file a complaint:

Director, U.S. Department of Health and
Human Services' Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201

800-368-1019 (voice) 800-537-7697 (TDD)

Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- | | | |
|-------------------|------------|----------------------------|
| ■ race | ■ religion | ■ sexual orientation |
| ■ color | ■ creed | ■ marital status |
| ■ national origin | ■ sex | ■ public assistance status |
| | | ■ disability |

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice) 800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax) Info.MDHR@state.mn.us (email)

DHS

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- | | | |
|-------------------|----------------------------|---|
| ■ race | ■ sexual orientation | ■ sex (including sex stereotypes and gender identity) |
| ■ color | ■ public assistance status | |
| ■ national origin | ■ marital status | ■ political beliefs |
| ■ creed | ■ age | |
| ■ religion | ■ disability | |

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

651-431-2670 or 800-657-3739

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለዎንም ከቆያ ይህንን ደኩመንት የሚተረጎም ለስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊

အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟိသျှန်ဟိသးဘဉ်တက့ၢ်. ဝဲန့ၢ်လိၣ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကကိၣ်းထံဝဲန့ၢ်လိၣ် တီလိၣ်စီတခါအံၤန့ၢ်, ကိးဘဉ်လိၣ်ဝဲန့ၢ်ဂီၢ်လၢသးအံၤန့ၢ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣຕຊາບ. ຖ້າທ່ານ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງໂທໂປທີ່ພາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.