NOTICE AND HEARINGS PROCESS

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I. INTRODUCTION

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

II. POLICY PRINCIPLES

A. An a/b 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. The local agency fails to complete all actions on an application by the application processing time standard (45th/90th day). The NCF-20023-NOTICE REGARDING THE STATUS OF YOUR APPLICATION FOR MEDICAID, will be generated by the NC FAST system.

3. An application is approved or benefits are continued. Use the NC FAST automated DSS-8108A/DSS-8108S, Notice of Benefits, or use the manual DMA-5003/DMA-5003s Approval Notice.

   Caseworkers must manually add the following sentence to the manual 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, add the following sentence to the manual DMA-5003/DMA-5003S, Approval Notice, if it does not contain the information: "Your partner may be potentially eligible also."

4. An application is denied or withdrawn. Use the automated or the manual DSS-8109/DSS-8109S, Notice of Benefits Denied or Withdrawn, to notify the applicant of the denial/withdrawal.

5. Benefits are changed, reduced, or terminated. Use the automated or the manual DSS-8110/DSS-8110S, Notice of Change in Benefits, to notify the beneficiary of either timely and adequate changes or terminations. For Medicare beneficiaries, 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/b has the right to appeal an action if they disagree with the local agency decision.

C. An a/b has the right to request an expedited hearing if it is determined a hearing held on a standard schedule could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.

D. In certain situations, an a/b has the right to have their benefits continued until a hearing decision is rendered.

E. A local hearing must be held at the local agency 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 beneficiary claims they are still disabled, request a state hearing.

F. An a/b has a right to a State hearing if they disagree with the local agency 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 Medicaid program category.

III. Authorized Representatives Entitled to notice.

A. Hierarchy of Representatives

1. Authorized Representative, power of attorney and guardian information must be keyed in NC FAST so that this individual receives Medicaid and Special Assistance notices.

2. Evidence fields have been created in NC FAST to allow for entry of PACE Agency or CAP case manager data in addition to Authorized Representative information. Key PACE Agency or CAP Manager information in the designated fields.

Refer to Job Aid: Adding or Editing MA Authorized Representative Evidence

3. 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.

   a. Legal Guardian (includes the local agency with custody or guardianship; if individual has a Guardian of the Person and a Guardian of the Estate, choose the Guardian of the Person).

b. Power of Attorney.

c. Health Care Power of Attorney.

d. Department of Social Services (placement responsibility only).

e. Spouse (Not separated).

f. Parent (for children under 21, a parent who is not the case head but who lives in the home).

g. Authorized Representative (An individual designated in writing by the applicant/beneficiary to assist with eligibility issues and who can have access to the information in the case file).

h. Authorized Representative as designated by SSA on SDX.

B. Representative Information for Applications

1. Contact the applicant and ask if they have any of the representatives listed in the hierarchy of representatives by reviewing the list with them. The applicant 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 they have more than one ask them to choose one to receive notices. Document the applicant's response. If the applicant is incapable of choosing, use the name of the Power of Attorney who has been helping with the case.

2. Ask the language preference for each representative named. Document the applicant's response.

3. If the application is being made by an informal representative, provide the representative with an authorized representative form, such as the DMA-5202C-ia/DMA-5202Csp-ia, Designation of the Authorized Representative Appendix C, for the applicant and the representative to sign.

4. 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 applicant does not respond to the initial request, send a second request.

   c. If the applicant 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 applicant 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.

1. The hospital must identify an individual to serve as the Authorized Representative. If an a/b's name and contact number are not on the Authorized Representative form, contact the hospital and obtain this information.

2. If the a/b 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 application, 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.

4. If the application is denied, maintain the hospital Authorized Representative information on the application.

D. Representative Information for Recertifications

1. No representative information in file

   a. Ask the beneficiary if they have a representative by reviewing the hierarchy of representatives list with them.

   b. If the beneficiary 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. Review the authorized representative information.

   b. Determine if the document is still valid.

      If the document has expired or will expire during the recertification process, request a new document using the DMA-5097/5097sp.

   c. If the beneficiary indicates they have one or more new representatives, find out the language preference of each representative.

   d. If the beneficiary has an informal representative, mail a "Designation of Authorized Representative" form, such as the DMA-5202C-ia/DMA-5202Csp-ia, to the beneficiary for signature, using the DMA-5097/5097sp.

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 recertification process, request a new document.

   b. If the beneficiary 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-5097s.

   c. If the beneficiary does not respond to the request for information, complete the recertification within the normal time frame. If the beneficiary provides the information after the recertification is completed, key the information when received.

E. SSI Cases

1 If there is no Authorized Representative information in NC FAST, Authorized Representative information from the SDX will automatically populate to the NC FAST case.

2. If there is Authorized Representative information in NC FAST, Authorized Representative information from SDX will not overlay the existing information. The Authorized Representative information from SSA is written to a report on NCXPTR.

   a. If the Authorized Representative information in XPTR is the same as that contained in NC FAST, no change is needed.

b. If the Authorized Representative information in XPTR conflicts with that in NC FAST, contact the beneficiary and ask which Authorized Representative is current. If the Authorized Representative has changed, request a copy of the new Authorized Representative document from the beneficiary. Key the new information into NC FAST when the documentation is received.

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

Refer to NC FAST Job Aid: Adding or Editing MA Authorized Representative Evidence

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 applicant of the reason they chose not to apply for Medicaid and their right to appeal if they believe the local agency discouraged them from applying for assistance.

Complete the notice of inquiry during the intake interview. Refer to MA-3200, Application, for instructions on completing the DMA-5095/DMA-5095S, Medicaid/Work First Notice Of Inquiry. Give the original to the applicant. File a copy in the case.

Refer to Job Aid: Record a Notice of Inquiry (DMA-5095)

B. NCF-20023, Notice Regarding the Status of Your Application for Medical Assistance:

The NCF-20023, Notice Regarding the Status of Your Application for Medical Assistance, notifies the applicant that their application has not been processed by the 45th/90th day processing time standard, and to contact their caseworker to find out the reason for the delay.

1. Automated Notice:

   The NCF-20023, Notice Regarding the Status of Your Application for Medical Assistance

   a. Will be automatically generated by NC FAST and mailed to the applicant when:

(1). The Medicaid application has not been processed by the 45th/90th day.

(2). The stop processing time has been end dated by the caseworker in NC FAST on the 45th/90th day and the Medicaid application has not been processed.

b. Will not be generated by NC FAST when:

(1). The Medicaid application has been processed by the 45th/90th day.

(2). The stop processing time begin date has been entered by the caseworker into NC FAST.

(3). The stop processing time has been end dated by the caseworker by the 45th/90th day, and the Medicaid application processed.

(4). A DMA-5098, Your Application for Medicaid is Pending, has been generated in NC FAST:

(a.) The DMA-5098/DMA-5098S, Your Application for Medicaid is Pending, form is used to provide the applicant with information regarding the status of their application and to allow the county to stop the application processing time.

(b). Refer to MA-2300. IX. Requesting Information

2. The local agency cannot use the application processing time standards nor use the NC FAST stop processing time option:

a. As a waiting period before determining eligibility,

b. As a reason for denying eligibility, or

c. As a reason to keep the NCF-20023 notice from generating because the local agency has not determined eligibility within the application processing time standards.

3. Under certain circumstances, days may be excluded from the application processing time. The NC FAST stop processing time may be used when the only information needed to determine eligibility is one of the following:

a. The local agency is waiting on a Disability Determination Services (DDS), disability decision.

b. The applicant requests additional time to provide information.

c. Medical records needed to determine emergency dates for non-qualified aliens,

d. Awaiting receipt of the FL-2/MR-2

e. Awaiting receipt of the CAP Plan of Care

f. Awaiting receipt of undue hardship documentation

g. Awaiting receipt of the Health Coverage for Workers with Disabilities (HCWD) enrollment fee and/or premium.

h. Awaiting receipt of the North Carolina Health Choice (NCHC) enrollment fee.

i. A change in situation, which affects eligibility, becomes known after the exclusion of days begins. Request the new or additional information following procedures and continue the exclusion.

j. Awaiting U.S. citizenship and identity documentation.

k. The individual is notified of the information needed to determine Medicaid eligibility using one of the following:

l. DMA-5098/5098S, Your Application for Medicaid is Pending,

m. DMA-5099/DMA-5099S, Your Application for Medicaid is Pending for a Deductible, or

n. DMA-5113, Notice of Right to Request a Hardship Waiver or notice of date hardship waiver was mailed.

For keying instructions, refer to NC FAST Job Aid:
Entering a Begin Date on Stop Processing Time Record
Entering an End Date on Stop Processing Time Record

4. 60/90-day Hearing Timeframe

Individuals have 60 days from the date of the notice to request a hearing and ask that a decision be made on their Medicaid application. That period is extended to 90 days for good cause. Refer to section V.B.4 below.

C. Approval Notice

1. Use the DMA-5003/DMA-5003S, Approval Notice, for notifying the a/b 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 transferring a case from Special Assistance to Medicaid.

3. Manual Notice Instructions

   a. General Requirements

      (1) If the notice is handwritten, the writing must be legible.

      (2) Use language that is clear and understandable.

      (3) Include month, day, and year. Example: 9/15/2011.

      (4) Keep a copy of each manual notice in the case.

   b. Instructions for Completing the DMA-5002/DMA-5002S

      (1) Enter the name of your county, the date the notice is mailed, and the beneficiary or case head/payee's name and mailing address.

      (2) For application approvals and open/shut cases, complete the following:

      Check the box beside the phrase:

      ☐ The application for: ___ Enter the applicant name _____ for: Enter Medicaid program/category_____ is approved. Beside the phrase Medicaid Identification Number (MID) is ____: Enter the MID for the applicant.

      DO NOT Check the box beside the phrase:

Eligibility For___ for ___ continues from____ to ____. This phrase is applicable for recertifications and change and circumstances.

If appropriate, check the box beside the phrase:

☐ Your patient monthly liability for long-term care is:

Month: ___ Enter Month Amount: ___ Enter amount

☐ Your Special Assistance/Adult Care Home Payment is: Enter payment amount.

☐ Your Special Assistance/Adult Care Home Payment is: Enter payment amount. _____

Check the box beside the phrase:

☐ Your Medicaid is approved starting _____ Enter the beginning months of Medicaid eligibility and ending_____ Enter the ending months of Medicaid eligibility.

If appropriate, check the box beside the phrase:

☐ Your Medicaid covers all necessary medical services. If you get Medicare from the Social Security Administration, Medicaid will pay your Medicare A and B premiums, deductible, and coinsurance beginning _____. Enter the first month of eligibility for Medicaid paid Medicare benefits, if appropriate.

☐ Medicaid pays only your Medicare A and B premiums, and Medicare cost sharing for Medicare and Medicaid covered cost, if appropriate.

☒ Medicare pays only your Medicare Part B premiums, if appropriate.

☐ Medicaid pays for limited services related to family planning, if appropriate.

☐ You Medicaid only pays for services related to pregnancy and for conditions that may complicate the pregnancy. This phrase is not applicable to Work First.

☐ Retroactive Medicaid coverage is approved for the period(s) of: Enter the months of retroactive Medicaid eligibility

Beside the phrase: If you receive Medicare, Medicare is responsible for your prescriptions. The state rules used to make this decision are in: ____Enter the Medicaid Manual as the State rules used to make this decision. ___which says that: ___ Enter the specific eligibility requirement used.

(3) Recertifications and change in situations that have been reviewed, and the beneficiary remains eligible, complete the following:

Check the box beside the phrase:

☐Eligibility for: __ Enter the beneficiary name. for: ___Enter the Medicaid program/category. continues from_____: Enter the beginning months. to: ___ Enter the ending months of Medicaid eligibility ___.

If appropriate, check the box beside the phrase:

☐ Your patient monthly liability for long-term care is: Month: ___ Enter Month Amount: ___ Enter amount

☐ Your Special Assistance/Adult Care Home Payment is: Enter payment amount.

☒ Your Special Assistance/Adult Care Home Payment is: Enter payment amount. _____

Beside the phrase: If you receive Medicare, Medicare is responsible for your prescriptions. The state rules used to make this decision are in: ____Enter the Medicaid Manual as the State rules used to make this decision. ___which says that: ___ Enter the specific eligibility requirement used.

(4) Denials:

If appropriate, check the box beside the appropriate program:

☐Medicaid ☐ Special Assistance/Adult Care Home

☐ Special Assistance/ In-home

Beside the phrase: is denied from: __Enter the month(s) for which assistance was denied and the specific reason for denial.

Enter the ___Medicaid Manual ___as the State rules used to make this decision. Enter the specific eligibility requirement used to deny eligibility.

(5) Hearing Rights:

Beside the phrase: The 60th day is ____Enter the 60th calendar day in the space provided. Day one, is the day following the day the notice is mailed or given to the beneficiary. If the 60th calendar day falls on a non-workday, the beneficiary has until the end of the next workday to request a hearing.

(6) Caseworker name, phone number, and address:

Enter the caseworker's name and county phone number on the line. Address: __Enter the mailing address of the local agency.

(7) "FOR OFFICE USE ONLY": Use this area to enter information to identify the beneficiary's:

(a) County case number,

(b) NC FAST case reference number, and

(c) Medicaid program/category.

c. Instructions for Completing the DMA-5003/DMA-5003S

(1) Enter the name of your county, the date the notice is mailed, and the beneficiary or case head/payee's name and mailing address.

(2) For application approvals and open/shut cases, complete the following:

Check the box beside the phrase:

☐ The application for: ___ Enter the applicant name _____ for: Enter Medicaid program/category_____ is approved. Beside the phrase Medicaid Identification Number (MID) is ____: Enter the MID for the applicant.

DO NOT Check the box beside the phrase:

Eligibility For___ for ___ is granted. Continues from____ to ____. Medicaid Identification Number (MID) is: ___This phrase is applicable for recertifications and change and circumstances.

Check the box beside the appropriate program phrase:

☐ Your Medicaid is approved starting _____ Enter the beginning months of Medicaid eligibility and ending_____ Enter the ending months of Medicaid eligibility.

☐ NC Health Choice for Children is approved for the period _____ Enter the beginning months of Medicaid eligibility and ending_____ Enter the ending months of Medicaid eligibility.

For Medicaid cases, check the box beside the appropriate phrase:

☐ Your Medicaid covers all necessary medical services.

☐ Your Medicaid pays only for services related to pregnancy and for conditions that may complicate the pregnancy.

☐ Medicaid pays for limited services related to Family Planning, if appropriate.

☐ Retroactive Medicaid Coverage is approved for the period(s) of _____, _____, _____ Enter the months of retroactive Medicaid eligibility

If appropriate, beside the phrase: If you receive Medicare, Medicare is responsible for your prescriptions. The state rules used to make this decision are in: ____Enter the Medicaid Manual as the State rules used to make this decision. ___which says that: ___ Enter the specific eligibility requirement used.

(3) For recertifications and change in circumstances that have been reviewed, and the beneficiary remains eligible, complete the following:

Check the box beside the phrase:

☐Eligibility for: __ Enter the beneficiary name. for: ___Enter the Medicaid program/category. is granted. Continues from_____: Enter the beginning months. to: ___ Enter the ending months of Medicaid eligibility ___. Beside the phrase Medicaid Identification Number (MID) is _____: Enter the MID for the applicant.

If appropriate, check the box beside the appropriate phrase:

☐ Your patient monthly liability for long-term care is: Month: ___ Enter Month Amount: ___ Enter amount

☐ Your Special Assistance/Adult Care Home Payment is: Enter payment amount.

☐ Your Special Assistance/Adult Care Home Payment is: Enter payment amount. _____

If appropriate, beside the phrase: If you receive Medicare, Medicare is responsible for your prescriptions. The state rules used to make this decision are in: ____Enter the Medicaid Manual as the State rules used to make this decision. ___which says that: ___ Enter the specific eligibility requirement used.

(4) Denials:

If appropriate, check the box beside the appropriate program:

☐Medicaid ☐ NC Health Choice

Beside the phrase: is denied from: __Enter the month(s) for which assistance was denied and the specific reason for denial.

Enter the ___Medicaid Manual ___as the State rules used to make this decision. Enter the specific eligibility requirement used to deny eligibility.

(5) Hearing Rights:

Beside the phrase: The 60th day is ____Enter the 60th calendar day in the space provided. Day one, is the day following the day the notice is mailed or given to the beneficiary. If the 60th calendar day falls on a non-workday, the beneficiary has until the end of the next workday to request a hearing.

(6) Caseworker name, phone number, and address:

Enter the caseworker's name and county phone number on the line. Address: __Enter the mailing address of the local agency.

(7) "FOR OFFICE USE ONLY": Use this area to enter information to identify the beneficiary's:

- County case number,
- NC FAST case reference number, and
- Medicaid program/category.

D. 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 their right to appeal if they disagree with the denial/withdrawal.

2. NC FAST will generate an automated DSS-8109A/DSS-8109S, Notice of Benefits Denied or Withdrawn, unless the automated notice is overridden.

   Refer to Job Aid: Manually Override a Notice Sent for Central Print

3. When the automated notice is overridden, document the reason for the override in the case and manually complete the DSS-8109/DSS-8109S, Notice of Benefits Denied or Withdrawn. See Manual Notice instructions below.

4. Automated Notice Instructions

   a. Denials

      (1) NC FAST will generate the notice based on reason entered for the denial.

      (2) Always use the appropriate denial reason when denying an application. 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 reason, manually complete the DSS-8109/DSS-8109S, Notice of Benefits Denied or Withdrawn. See Manual Notice instructions below.

   b. Withdrawals

      (1) NC FAST will generate the notice based on the reason entered by the case worker for 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 case the reason for the applicant's withdrawal and all alternatives to withdrawal that were explained.

      Refer to MA-3200, Application, for specific documentation instructions for withdrawals.

   c. NC FAST will enter the Medicaid policy manual section that supports the denial or withdrawal reason entered.

d. The NC FAST generated notice will include WHEN TO ASK FOR A HEARING section for the applicant. 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.

e. The local agency must ensure the notice generated and shows in NC FAST as (sent central print) to the beneficiary.

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

5. Manual Notice Instructions

a. General Requirements

(1) If the notice is handwritten, the writing must be legible.

(2) Use language that is clear and understandable.

(3) Include the month, day and year. Example: December 15, 2018 or 12/15/2018.

(4) Keep a copy of each manual notice in the case.

b. Instructions for Completing the DSS-8109/DSS-8109S.

(1) Enter the name of your county, the date the notice is mailed and the beneficiary or case head/payee's name and mailing address.

(2) Enter the Medicaid program/category for which the person applied in the space following the words "Your application for". If this is an application for Medicaid, write "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 reasons for appropriate wording.

(5) Check the "If this box is checked" box if a separate evaluation (spin off) is being done for Medicaid.

(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 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.

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

(9) Use the "For Office Use Only" area to enter information to identify the applicant's:

(a) County case number, and

(b) NC FAST case reference number, and

(c) Medicaid program/category.

(10) Mail or give the original to the applicant. File a copy in the case.

(11) Mail a copy to all authorized representatives.

E. DSS-8110/DSS-8110S Notice of Change in Benefits

The DSS-8110A/DSS-8110S, Notice of Change in Benefits, is used to notify the beneficiary when benefits are changed, reduced or terminated. It notifies the beneficiary 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.

NC FAST automatically generates a DSS-8110A/DSS-8110S, Notice of Change in Benefits, unless the automated notice is overridden. Refer to the Job Aid: Manually Override a Notice Sent for Central Print

1. Adequate Notice

The beneficiary 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 beneficiary.

b. The agency has factual information confirming the death of a beneficiary.

c. A beneficiary is admitted to a public institution and no longer qualifies for assistance.

d. A beneficiary signs and dates a written statement to have his assistance terminated or reduced. The request must specifically request Medicaid termination. Document that the beneficiary understood that they may still be eligible for Medicaid and chose not to continue.

e. A beneficiary 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 beneficiary's physician prescribes a change in level of medical care, i.e., skilled or intermediate nursing care or long-term hospitalization.

g. A beneficiary's whereabouts are unknown, and the post office returns two local agency mail correspondence indicating no forwarding address.

Review all other programs for reported address and attempt to contact the applicant by phone, mail, and electronic means, prior to termination of benefits.

h. A beneficiary begins to receive assistance in another state, territory, or commonwealth with no break in benefits.

i. A North Carolina Health Choice beneficiary becomes eligible for Medicaid.

2. Timely Notice

a. Use a timely notice any time assistance is reduced or terminated except for the situations described in IV. E.1.

b. The beneficiary must be informed in writing of the intended change or termination prior to taking the action.

c. 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. When the language on the NC FAST generated DSS-8110 is not appropriate, or a change in PML or deductible balance is displayed in NC FAST.

b. A case action involves a program transfer from Special Assistance to Medicaid.

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, NC FAST produces and mails an automated DSS-8110/DSS-8110S, Notice of Change in Benefits. The word "TIMELY" is printed on the automated notice.

The local agency must ensure the notice generated and shows in NC FAST as (sent central print) to the beneficiary.

b. When you make a change to reduce or terminate benefits by entering an adequate reason, NC FAST produces and mails an automated DSS-8110A/DSS-8110S, Notice of Change in Benefits. The word "ADEQUATE" is printed on the automated notice.

The local agency must ensure the notice is generated and shows in NC FAST as (sent central print) to the beneficiary.

c. When the appropriate evidence is entered correctly into NC FAST, the automated notice is produced and mailed the next State work day after the change processes.

Refer to Job Aid: DSS-8110
DSS-8110 Common Mistakes
DSS-8110 Reasons and Outcomes

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/b and file a copy in the case. Refer to Manual Notice Instructions below.

6. Manual Notice Requirements

a. General Requirements

(1) If the notice is handwritten, the writing must be legible.

(2) Use language that is clear and understandable.

(3) Include month, date and year. For example, write December 15, 2011 or 12/15/2018.

(4) Keep a legible copy of each manual notice in the case.

b. Instructions for Completing the DSS-8110/DSS-8110S.

(1) Enter the name of your county, the date the notice is mailed, and the beneficiary or case head/payee's name and mailing address.

(2) "What The Change Is:" Explain exactly what the change is using language that is easy to understand.

(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."

(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 NC FAST.)

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 beneficiary is on Medicare buy-in, write on this line whether payment of the Medicare premium will "continue" or "stop." If the beneficiary 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 beneficiaries 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 beneficiary does not have a right to continued benefits.

(9) Timely Notice: Check the second block if the notice is a timely notice. The beneficiary'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 beneficiary 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 beneficiary 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.

(11) "FOR OFFICE USE ONLY" Use this area to enter information to identify the beneficiary's:

(a) County case number,
(b) NC FAST case reference number, and
(c) Medicaid program/category.

7. Automated Notice Effective Dates

a. Timely Notice

(1) When you enter a timely reason in NC FAST, the date of the automated timely notice is the first State workday after the change successfully processes in NC FAST. The notice is also mailed on this date.

- Example: The timely reason is entered in NC FAST August 2nd (Friday). The notice is dated and mailed on August 5th (Monday).

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

- Example: The timely reason entered August 2nd (Friday). The notice is dated August 5th (Monday). The 10-day period begins on August 6th. Therefore the 10th workday is August 19th (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 cancelled. Refer to instructions in IV.E.7.e. for cancelling timely action.

In the example above, NC FAST is updated with the changed information on August 20th (Tuesday night), unless the action cancelled.

b. Timely Notice With Override of Automated Notice

(1) When you enter a timely reason and you override the automated notice, NC FAST will count 10 workdays and update the system on the same schedule as it does when the notice is not overridden.

(2) Overriding the automated notice does not prevent NC FAST from processing the timely action on the night of the first State workday following the 10-workday period.

c. Adequate Notice

(1) When you enter an adequate reason, the date of the automated adequate notice is the first State workday after the adequate reason processes. The notice is also mailed on this date. NC FAST is updated with the changed information the night the change is entered.

(2) When you enter an adequate reason and you override the automated notice, NC FAST 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 NC FAST.

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 beneficiary. On the workday following the 10th workday of the manual notice, enter in NC FAST an adequate reason and override the automated notice. The beneficiary 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 and override the automated notice. If the beneficiary comes in during the 10-day period and establishes ongoing eligibility with no change. Document and send appropriate notice.

e. Cancelling Timely Action

If you use a timely reason and the beneficiary responds within the 10 workdays, and eligibility continues with no change in benefits. Document and send appropriate notice.

f. Demographic Changes During the Timely Notice Period

You can enter in NC FAST case changes during the timely notice period. These include address changes and any changes to individual data such as deletions, add-individual, or date of death.

h. If the change is entered too late in the month (after pull cutoff/pull check) to make the termination or change effective the next calendar month, NC FAST automatically changes the effective date.

Example: NC FAST Product Delivery Case (PDC) showing a termination effective date of March 31st and a timely reason is entered on March 14th. The day after the 10th workday is March 30th. Because the action effective day falls after pull cutoff/pull check, NC FAST will change the termination effective date to April 30th.

8. Schedules of Timely Actions Pending in NC FAST

a. Automated Timely Notice Schedule When NC FAST Issues a Notice

FRI Mar 13	MON Mar 16	TUES Mar 17	MON Mar 30	TUES Mar 31	Night of March 31
Workday #1 Change entered	Workday #2 Notice is mailed	Workday #3 Notice day #1	Workday #12 Notice day #10 - 10 days expires	Workday #13 Notice day #11 5:00 deadline to cancel action.	Night of Workday #13 NC FAST updated

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 Change entered with override case worker mails notice	Workday #2 Notice day #1	Workday #10 Notice day #10 - 10 days expires	Workday #12 Notice day #11 5:00 deadline to delete or cancel the action	Night of Workday #12 NC FAST updated

F. Automated Notice

NC FAST displays a copy of each individual notice it generates and mails. It also displays cases for which the notice was overridden or cancelled.

V. HEARING PROCESS

A. Purpose

1. Local

The purpose of the local hearing is to allow the local agency to explain the action in question and gives the applicant/beneficiary (a/b) or designated authorized representative an opportunity to explain why they feel that action should not take place.

2. State

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

B. Applicant's/Beneficiary's Rights

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

a. The local agency denies an applicant the opportunity to make an application on the day they first appear at the agency and wishes to apply.

b. The applicant/beneficiary alleges they were discouraged for any reason from applying for assistance. See MA-3200, Application, for the definition and examples of discouragement.

c. The applicant/beneficiary alleges the local county agency improperly withdrew their application. See MA-3200, Application, for the definition of improper withdrawals.

d. The applicant/beneficiary alleges the local county agency improperly denied their application. See MA-3200, 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 beneficiary's, unless the reason for the hearing is incorrect computation or there is a factual issue regarding whether the change applies.

f. The applicant/beneficiary disagrees with the amount of their deductible or patient monthly liability.

g. The local agency fails to act within the required time standards.

h. The local agency fails to act promptly on a request for a review of the case situation.

i. The applicant/beneficiary disagrees with the determination of:

(1) The community spouse income allowance, or

(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. The beneficiary disagrees with the establishment of an overpayment. See MA-3535, Recipient Fraud and Abuse Policy and Procedures.

j. The beneficiary disagrees with the establishment of an overpayment. See Policy, Beneficiary Fraud and Abuse Policy and Procedures.

2. The applicant/beneficiary may request the hearing verbally or in writing.

a. via the EPASS portal

(1) Hearing request submitted via this method will arrive as a task called Review Online Appeal Request task. The task will be

located in the queue called NC FAST <County Name> Online Appeal Request queue to be managed by the NC FAST case owner's supervisor or the agency designated representative. The supervisor or the agency designated representative must monitor this queue daily throughout the day.

(2) The local agency must review these requests to determine whether the individual meets the criteria for a standard or expedited hearing.

(3) Hearing request date is the date received during normal business hours. Next business day for request received after normal business hours.

(4) Refer to Job Aid: Getting Tasks from Work Queues

b. Telephonically

Hearing request date is the date of the telephone request.

c. In person

Hearing request is the date received in the agency (including outpost location) during normal business hours. Next business day for request received after normal business hours.

d. Through all electronic data sources

Hearing request is the date received in the agency during normal business hours. Next business day for request received after normal business hours.

e. In writing and signed by the applicant/beneficiary/designated authorized representative

Hearing request is the date received in agency during normal business hours. Next business day for request received after normal business hours.

3. Expedited Hearing:

An applicant or beneficiary may request an Expedited Hearing if the standard timeframe for adjudicating a hearing could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.

a. The applicant/beneficiary must provide documentation that includes but is not limited to those listed below on the day of the request:

(1) Doctor certifies in writing that it is in his/her professional opinion that a standard hearing timeframe for adjudicating a hearing could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.

(2) Statement from a professional who has knowledge of their situation (for example: nurses, or social workers).

(3) Statements from family and friends will not be acceptable.

b. If the applicant/beneficiary provides documentation to meet the criteria for an expedited hearing on the day of the request. The caseworker must:

(1) Notify the applicant/beneficiary on the day the expedited hearing request is received that the expedited hearing request is granted.

(a) Notice must be provided orally or through electronic means.

(b) If oral notice is provided, the agency must follow up with written notice, which may be through electronic means, if consistent with the individual's choice to receive notices electronically instead of by mail.

c. If the applicant/beneficiary does not provide documentation to meet the criteria for an expedited hearing on the day of the request. The caseworker must:

(1) Notify the applicant/beneficiary on the day the expedited hearing request is received that the expedited hearing request is denied and will proceed on a standard hearing schedule.

(a) Notice must be provided orally or through electronic means.

(b) If oral notice is provided, the agency must follow up with written notice, which may be through electronic means, if consistent with the individual's choice to receive notices electronically instead of by mail.

d. In cases involving issues other than disability, the applicant/beneficiary has the right to request a State hearing only after a local hearing has been held and a decision has been rendered.

(1) Expedited hearing requests for non-disability requests can only be held at the local level.

(2) If a State hearing is requested after an expedited hearing was held at the local level and a decision has been rendered. The State hearing is handled on a standard schedule.

4. The applicant/ beneficiary 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 local agency caused them not to apply, caused them to withdraw their application, or that the denial was improper.

b. Good cause is defined as:

(1) Failure of the a/b to receive the notice of action, or

(2) Extended hospitalization of the a/b, spouse, child, or parent of the a/b, or

(3) Failure of a representative acting on the a/b's behalf to meet required time frames, or

(4) Illness resulting in incapacity, incompetence, or unconsciousness of the a/b and there is no representative acting on their behalf, or

(5) Death of the a/b or their representative, or

(6) Failure of the local agency to provide sufficient or correct information regarding appeal rights.

c. The a/b 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/b, their representative, or other individual knowledgeable of situation.

5. In cases involving issues other than disability, the applicant/beneficiary has the right to request a State hearing only after a local hearing has been held and a decision has been rendered.

   (a) Expedited hearing request for non-disability requests can only be held at the local level.

   (b) If a State hearing is requested after an expedited hearing was held at the local level and a decision has been rendered. The State hearing is handled on a standard schedule.

6. In cases involving a question of disability, an applicant/beneficiary 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 beneficiary is ineligible for any other Medicaid programs, yet the beneficiary claims they are still disabled.

   Within 5 calendar days of the request for a hearing, the county director or their 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 beneficiary.

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

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

   a. Beneficiaries Who Receive Timely Notice

      (1) If a beneficiary 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 beneficiary),
      (2) The beneficiary has the right to continued benefits until the end of the month in which the local hearing decision is rendered,
      (3) Except when the reduction or termination involves a disability determination or the beneficiary waives their right to continued benefits.
      (4) If the reduction or termination involves a disability determination, the beneficiary 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.

(5) The beneficiary is not entitled to continued benefits if the appeal is requested after the 10-workday period.

(6) When the beneficiary requests the hearing, advise the beneficiary:

(a) If the reduction or termination of benefits is affirmed by the local or state hearings officer, the beneficiary may be required to repay the benefits 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) The beneficiary has the right to choose not to continue to receive benefits.

(7) In some cases, a hearing decision upholding the local agency'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.

b. Beneficiaries Who Receive <u>Adequate Notice</u>

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

8. The a/b must request a State hearing within 15 calendar days of the mailing of the local hearing decision, unless they can show good cause for a later request as outlined in IV.B.4.

9. The a/b has the right to be represented at the hearing by the person of their choice, including an attorney obtained at his expense.

10. If at any point, the a/b does not exercise their right to a hearing or the right to continued benefits, the a/b still has the right to reapply.

C. Request for a Hearing

How the local agency handles the applicant/beneficiary's request for a hearing depends on the action in question and whether a standard or expedited hearing has been requested.

1. Local

(a) Immediately notify the appropriate county staff when an a/b requests a local hearing. Inform the a/b that the local hearing officer will be contacting them regarding their request.

(b) The local hearing must be held:

Standard Hearing	Expedited Hearing
Five (5) days after the request is received	Three (3) days after the request is received

2. State

a. When the applicant/beneficiary requests a State hearing that does not involve a question of disability/incapacity:

Standard Hearing Procedures:	Expedited Hearing Procedures:
The local agency must submit on the day the a/b request the DSS-1473, Request for State Appeal, to the Chief Hearing Officer, Hearing and Appeals Section, Division of Social Services: a. Attach a copy of the local hearing decision, if applicable. b. Attach to the DSS-1473, Request for State Appeal	Does not apply. After the local agency decision is rendered. Request for a State hearing are handled on a standard hearing schedule. Follow standard hearing procedures.

• 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. c. 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 local agency 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.	

b. When the applicant/beneficiary requests a State hearing that involves a question of disability/incapacity:

Standard Hearing:	Expedited Hearing
The local agency within 5 calendar days of the day of the a/b request must submit the DSS-1473, Request for State Appeal, to the Chief Hearing Officer, Hearing and Appeals Section, Division of Social Services: a. Attach a copy of the local hearing decision, if applicable. b. Attach to the DSS-1473, Request for State Appeal • All medical records dated within the last 12 months when the	The local agency must fax on the day of the a/b request the DSS-1473B Addendum for Expedited MAD Medical Determination, to the Chief Hearing Officer, Hearing and Appeals Section, Division of Social Services: a. Fax the DSS-1473B Addendum, for Expedited MAD Medical Determination to 919-715-1910 b. Attach to the DSS-1473B Addendum, Expedited MAD Medical Determination form:

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. c. 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 local agency 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.	• Medical records consisting of physical examinations, signs, symptoms, laboratory finding, etc. documenting the appellant's urgent health need and not just a doctor's opinion of diagnosis/disability/function.) • If the applicant/beneficiary does not provide documentation to support the urgent need for an expedited hearing and appeal. The caseworker must: ○ Contact and inform the appellant on the day the expedited hearing request is received that the expedited hearing will transition into a standard fair hearing time frame. c. The caseworker must call the Hearings and Appeals Section to confirm that the Expedited Appeal Request has been received by fax. d. If there has been no response from a State hearing officer within 7 days of the date the DSS-1473B Addendum, Expedited MAD Medical Determination, 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

When 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 case, 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/b of the time and place of the hearing.

2. The local hearing must be held within:

Standard Hearing	Expedited Hearing
Five (5) calendar days after the request is received	Three (3) calendar days after the request is received

3. The a/b may request and is entitled to receive a postponement of the scheduled hearing if good cause exists.

   a. Local

   If the a/b 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/b has good cause to postpone the hearing when:

      (1) There is a death in the a/b's family.

      (2) The a/b or someone in their family is ill.

      (3) The a/b is unable to obtain representation.

(4) The a/b's representative has a conflict with the scheduled date.

(5) The a/b is unable to obtain transportation.

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

E. Place

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

F. Seeing the Record

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

G. Summary

1. The caseworker must prepare an original and two copies of the hearing summary discussing the local agency 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/b and file a copy in the eligibility record.

H. Attendance

Attendance at the hearing is limited to the a/b, the designated representative, appropriate representatives of the local agency and/or State, and any witnesses that the a/b or the local agency 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 their designee presides at the local hearing and ensures that the oath or affirmation is administered to all participants.

(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/b and the local agency may be represented by attorneys or other individuals obtained at their expense.

4. The local agency and the a/b must each name someone to present their testimony and to call as witnesses. Any person testifying must be sworn in.

5. The local agency 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/b or their representative may question the county's witnesses or representative.

6. The a/b or their designated authorized representative may then explain why they feel the local agency's action should not be implemented. He may call witnesses, one at time. The hearing officer may question witnesses during testimony. When the a/b's testimony has ended, the local agency representative may question the a/b, witnesses, or representative.

7. Representatives for the local agency and the a/b may present closing statements summarizing their view of the situation in question.

J. Decision

1. Local

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:

Standard Hearing:	• Within five (5) calendar days of the date of the local hearing. Retain a copy in the case. • The decision may be sent electronically if the individual elects to receive electronic communication. Retain a copy in the case.
Expedited Hearing:	• The local hearing officer must first attempt to contact the applicant/beneficiary with the decision on the day the decision is rendered. • Sent to the applicant/beneficiary by certified mail within two (2) calendar days of the date of the local hearing. Retain a copy in the case. • The decision may be sent electronically if the individual elects to receive electronic communication. Retain a copy in the case.

2. State

The State hearing officer must render 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:

Standard Hearing:	• Not more than 90 calendar days from the date of the request for the hearing unless the hearing was delayed at the applicant/beneficiary's request.
Expedited Hearing:	• Not more than 5 workings days from the date of the request for the hearing unless the hearing was delayed at the applicant/beneficiary's request.

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

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

Standard Hearing:	• After 60 days, the worker needs to contact DSS Hearing and Appeals to check the status of the decision.
Expedited Hearing:	• After 3 working days, the worker needs to contact DSS Hearing and Appeals to check the status of the decision.

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

d. The local agency or the applicant/beneficiary 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.

e. 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.

f. If the party that requested oral argument fails to appear at the hearing for oral argument, the tentative decision becomes final.

K. Implementation of Decision:

1. Local

a. Applications

The local county must implement a State appeal decision within:

Standard Hearing:	• Five (5) workdays of the date the DSS-1894, Notice of Decision, becomes final.

Expedited Hearing:	• Two (2) workdays of the date the DSS-1894, Notice of Decision, becomes final.

b. Terminated/Modified Cases

The local county must implement a State appeal decision within:

Standard Hearing:	• Fourteen (14) calendar of the date the DSS-1894, Notice of Decision, becomes final.
Expedited Hearing:	• Two (2) workdays of the date the DSS-1894, Notice of Decision, becomes final.

c. The local county or the a/b 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 local agency 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 local agency 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-3200, 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-3530, Corrective Actions and Responsibility for Errors, for override instructions.

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 beneficiary has also filed a timely appeal of the Social Security/SSI denial or termination.

   b. If the beneficiary 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/b is not satisfied with the local hearing decision, he may request a State hearing through the local agency. 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/Beneficiary

If the a/b 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. Local Agency and State

Neither the local agency nor the State may appeal a hearing decision to Superior Court.