State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

June 15, 2016

To: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY PUBLIC HEALTH DIRECTORS
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL CONSORTIA/SAWS PROJECT MANAGERS

Letter No: 16-14

SUBJECT: Updated Guidance: Discontinuance Notice of Action - Over Income and Not Otherwise Medi-Cal Eligible
(Reference: All County Welfare Directors Letter 15-33)

Purpose

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide updated guidance to counties and Statewide Automated Welfare System (SAWS) on the requirements for issuing a Notice of Action (NOA) to individuals who are discontinued from Medi-Cal as a result of the following:

- Being over income for the appropriate Modified Adjusted Gross Income (MAGI) program;
- Not eligible for any of the Consumer Protection Programs (CPPs), such as Continuous Eligibility for Children or Transitional Medi-Cal; **and**
- Having no potential eligibility for Non-MAGI Medi-Cal programs after ex parte review, declining a non-MAGI assessment, or being determined ineligible for non-MAGI.

For more information about the population described in the letter, please see ACWDL 15-33.

Use of the Automated NOA

Previous guidance issued in ACWDL 15-33 provided counties with a manual Over Income NOA to be sent to beneficiaries who were being discontinued from Medi-Cal as a result of the reasons described in this letter. Additionally, ACWDL 15-33 informed

counties that with the implementation of Senate Bill (SB) 1341 (Chapter 846, Statutes of 2014), SAWS would be programmed to automatically generate the Over Income NOA for the appropriate scenarios and the manual process described in ACWDL 15-33 was to be used only until such time as SAWS implements SB 1341.

As a result of the implementation of SB 1341, counties are hereby directed to stop issuing the manual Over Income NOA as directed in ACWDL 15-33, effective immediately. The automated Over Income NOA generated by SAWS for the individuals described by this letter provides more detail related to the income, household size and income limit for the individual who is losing eligibility and, therefore, the manual NOA provided in ACWDL 15-33 is no longer considered adequate.

Updated Language for the Automated NOA

As a result of discussions between the Department of Health Care Services (DHCS), Covered California, the California Welfare Directors Association and stakeholders, updated NOA language has been developed for the automated Over Income NOA in English and Spanish to alert transitioning beneficiaries of the steps to take to avoid a gap in health coverage (See Attachments 1 and 2). Additionally, DHCS is translating the updated NOA language into the remaining threshold languages, which will be provided through an upcoming Medi-Cal Eligibility Division Information Letter (MEDIL) once they are completed. **SAWS are hereby directed to replace the existing automated Over Income NOA language with the updated Over Income NOA language in English and Spanish, effective immediately.** To the extent possible, counties are to utilize the updated Over Income NOAs included with this letter until such time as they are programmed by SAWS.

County Assistance to Avoid a Gap in Coverage

Counties must ensure that the timely and adequate discontinuance NOA described in this letter is issued to all individuals who are discontinued from Medi-Cal due to an increase in income for the appropriate MAGI eligibility group, where the individual has no potential eligibility for any CPPs or non-MAGI Medi-Cal after ex parte review, or where the individual declines an assessment for non-MAGI Medi-Cal after receiving the non-MAGI screening packet, or where the individual is determined ineligible for non-MAGI Medi-Cal including CPPs. Please note that individuals described in this letter who are determined over income for MAGI Medi-Cal and are evaluated and found ineligible for Non-MAGI programs, would be sent the NOA described in this letter along with the appropriate Non-MAGI denial NOA describing why the person was found ineligible for Non-MAGI Medi-Cal. Please see ACWDL 14-18 for guidance on the ex parte and non-MAGI review process. Sending the discontinuance notice to individuals

discontinued from Medi-Cal for the reasons outlined in this ACWDL is required whether or not an individual has been determined eligible for Advanced Premium Tax Credits (APTCs), Cost Sharing Reductions (CSRs) or unsubsidized coverage per Welfare and Institutions Code, Section 14005.37(o).

As described in ACWDL 14-18, individuals who are discontinued from Medi-Cal as a result of the reasons described in this letter are immediately evaluated by the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) business rules engine for APTCs and CSRs through Covered California.

> **IMPORTANT NOTE:** Individuals who become eligible for a subsidized or unsubsidized Covered California plan as a result of a loss of Minimum Essential Coverage (MEC), including Medi-Cal, are not subject to the "15-day rule" to pick a plan. They may pick a Covered California plan before the end of the month in which they are losing MEC and their Covered California coverage will start the first of the following month, provided they pay their premium by the due date provided in the first bill.
>
> As described in ACWDL 14-18, counties are reminded that if the beneficiary is found eligible for APTC/CSR benefits, the county shall assist the individual in completing the enrollment process into APTC/CSR, including assisting with health plan selection, if so requested. This means that if the county is contacted by the beneficiary for assistance in enrolling in a plan, the county must provide this assistance by explaining the options available to the beneficiary and assisting in enrollment if a health plan is chosen by the beneficiary. If the beneficiary is not ready to make a plan selection at that time, counties should provide the beneficiary with the Covered California Service Center contact information at (800) 300-1506 and remind the beneficiary about the timelines to avoid a gap in coverage. If counties experience difficulties with plan selection through CalHEERS, they should follow their county processes to report technical issues to the CalHEERS Help Desk, or escalate business process issues to the Covered California County Liaison Helpline.

For beneficiaries being discontinued from Medi-Cal, this means that from the date the timely discontinuance NOA is sent out, the beneficiary may have less than ten (10) days to pick a plan to avoid a gap in coverage. The individual will continue to have sixty (60) days from the date of the loss of coverage to pick a plan; however, they must do so before their Medi-Cal ends if they wish to avoid a gap in coverage. Additional information has been added to the Over Income NOA included with this letter to inform individuals of the need to act immediately to avoid a gap in coverage.

For example, if an individual transitioning from Medi-Cal to Covered California receives their Medi-Cal discontinuance NOA on March 18, they can pick a Covered California plan up until March 31 and pay their premium and their Covered California coverage would start April 1. If the person does not pick a plan by March 31 and pay their premium by the due date, they will be uninsured in April.

NOA Policy Requirements

All requirements outlined in ACWDL 13-13: *Medi-Cal General Notice of Action (NOA) Policy*, including the requirement to include the NA Back 9 hearing rights information and the multilingual notification, and the requirement to adhere to timely 10-day notice, must be followed. Counties are reminded that the earlier in the month this notice is sent, once the determination is made, the more time the individual is provided to act immediately to avoid a gap in coverage.

Additionally, for MAGI eligibility determinations, counties must include the Affordable Care Act Bureau designation on the NA Back 9, as required by the California Department of Social Services. This ensures the hearing requests based on MAGI eligibility determinations are routed to the correct hearing location. The English and Spanish versions of the correct NA Back 9 to be used for MAGI eligibility determinations are included with this letter as attachments 3 and 4. Counties may include the local legal aid agency within the designated area of the NA Back 9.

If you have any questions or require additional information, please contact Alison Brown at (916) 319-9565 or by email at Alison.Brown@dhcs.ca.gov.

Original Signed By

Sandra Williams, Chief
Medi-Cal Eligibility Division

Attachments

NOTICE OF ACTION
DISCONTINUANCE OF BENEFITS

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker ID Number: _____
Worker Telephone Number: _____
Office Hours: _____
Office Address: _____

DISCONTINUANCE NOTICE FOR:
Insert Name(s) Here

We have looked at all of the information we have about your case. Based on this information, your eligibility for Medi-Cal will end on the last day of <MONTH YYYY>.

The reason your Medi-Cal is stopping is:

You no longer qualify for Medi-Cal. This is because your household income is above the allowed amount. We counted your household size and income to make our decision. For Medi-Cal, your household size is <MAGI_SIZE> and your monthly household income is $<MAGI_INCOME>. The monthly Medi-Cal income limit based on your age and household size is $<MAGI_INCOME_LIMIT>. Your income is above this limit, so you do not qualify for Medi-Cal.

We used the information you gave us and our records to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, contact the Medi-Cal office at the number listed above immediately. You also have the right to appeal. See below for more information on your appeal rights.

If you are pregnant or disabled and have not reported this information, you may be able to stay on Medi-Cal. If you would like to see if you can stay on Medi-Cal, please tell us by calling the Medi-Cal office at the number listed above to report your pregnancy or disability.

TAKE ACTION *NOW* TO GET NEW HEALTH COVERAGE
Since your income is now too high for Medi-Cal, you have been referred to Covered California. Through Covered California, individuals and families can get help paying for private health insurance. You may qualify for financial help that can lower monthly costs (called premiums) and copayments. The amount of financial help is based on household size and annual household income. You do not need to fill out a new application.

Your Medi-Cal is ending and you must act quickly to get covered. You must pick a Covered California health plan before your Medi-Cal coverage ends and pay your premium by the due date provided in the first bill so that you do not go without health care coverage. You have an additional 60 days from the time your Medi-Cal ends to enroll in a Covered California health plan. **However, if you do not pick a Covered California plan before your Medi-Cal ends you will not have health coverage the following month**.

Call your local county office at the number listed on this notice or Covered California at 800-300-1506 to ask questions about Covered California or to pick a plan. If you would like help picking a Covered California health plan, you can contact a Covered California Certified Enrollment Counselor or Certified Insurance Agent; they can help you figure out the best plan for you. To find an enrollment counselor or agent near you, go to www.CoveredCA.com and click on "Find Local Help.

Please Note: Other family members with different eligibility may receive a separate notice.

DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)
If you already have a plastic Benefits Identification Card (BIC), do not throw it away. You can use it until your Medi-Cal ends. Also, you can use it again if you become eligible for Medi-Cal at a future date.

YOU HAVE A RIGHT TO APPEAL IF YOU DO NOT AGREE
If you do not agree with this action or you think we made a mistake, you can appeal. If you want to keep your Medi-Cal while you appeal, you must appeal before your Medi-Cal ends. Otherwise, you have only 90 days to ask for a hearing. The 90 days started the day the county sent you this notice. See the reverse side of this notice to learn how to appeal. <REGULATION> is the regulation or law we relied on for this decision.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
DESCONTINUACIÓN DE BENEFICIOS

Fecha de la notificación: _____
Número del caso: _____
Nombre del trabajador: _____
Número del trabajador: _____
Teléfono del trabajador: _____
Horario de la oficina:_____
Dirección de la oficina:_____

NOTIFICACIÓN DE DESCONTINUACIÓN PARA:
Insert name(s) here

Hemos revisado toda la información que tenemos disponible de su caso. Basado en esta información, su Medi-Cal terminara el último día de <Month Year>.

La razón por la cual sus beneficios terminan es la siguiente:

Usted no califica para Medi-Cal porque los ingresos de su hogar son más del límite permitido para Medi-Cal. Tomamos en cuenta el tamaño de su hogar e ingresos para tomar nuestra decisión. Para Medi-Cal, el tamaño de su hogar es de <MAGI_SIZE>, y el ingreso mensual de su hogar es de <MAGI_INCOME>. El límite de ingresos mensuales de Medi-Cal para su edad y el tamaño de su hogar son <MAGI_INCOME_LIMIT>. Usted no califica para Medi-Cal porque sus ingresos son más del límite.

Utilizamos la información que nos dio y la información de nuestros registros para tomar nuestra decisión. Si tiene preguntas o cree que hemos hecho un error, o si tiene más información que no nos haya proporcionado, llame a su trabajador(a) de elegibilidad de inmediato al número mencionado arriba. Usted también tiene el derecho de apelar. Vea abajo para más información sobre su derecho de solicitar una audiencia.

Si está embarazada o tiene una discapacidad y no ha reportado esta información, puede mantener su Medi-Cal. Si gustaría ver si usted puede mantener su Medi-Cal, por favor llame a la oficina de Medi-Cal al número mencionado arriba y reporte su embarazo o discapacidad.

TOME MEDIDAS *AHORA* PARA OBTENER COBERTURA DE SALUD NUEVA
Ya que sus ingresos son muy altos para Medi-Cal, usted ha sido referido a Covered California. A través de Covered California, individuos y familias pueden obtener ayuda para pagar por seguro médico privado. Usted puede calificar para ayuda financiera que reduce los costos mensuales (llamado prima) y copago. La cantidad de ayuda financiera es basada en el tamaño del hogar e ingresos anuales. No es necesario llenar otra aplicación.

Su Medi-Cal se termina y debe actuar rápido para conseguir cobertura. Tiene que elegir un plan de salud de Covered California antes que se termine su Medi-Cal y tiene que pagar su prima antes de la fecha de vencimiento proveído en la primera factura para que no se quede sin cobertura de salud. Usted tiene 60 días adicionales de cuando su Medi-Cal termina para inscribirse a un plan médico de Covered California. **Sin embargo, si usted no elige un plan de Covered California antes de que su Medi-Cal termine usted no tendrá beneficios médicos en el siguiente mes.**

Llame a su oficina local del Condado al número de teléfono mencionado arriba o Covered California al 1-800-300-1506 para preguntar sobre Covered California o para elegir un plan de salud. Si necesita ayuda en elegir un plan de salud de Covered California, puede contactar un Consejero Certificado de Inscripción o Agente de Seguros Certificado. Ellos pueden ayudarle averiguar cual plan de salud es mejor para usted. Para encontrar un Consejero Certificado de Inscripción o Agente de Seguros Certificado cerca a usted sigua el enlace www.CoveredCa.com y haga clic en “encuentra ayuda en su área”.

Favor de notar: otros miembros de su familia con elegibilidad diferente pueden recibir un aviso separado.

NO TIRE SU TARJETA DE MEDI-CAL (Benefits Identification Card (BIC))
Si usted tiene una tarjeta BIC, no la tire. Usted puede usarla hasta que su Medi-Cal termine. También, podrá usarla de nuevo si es elegible para Medi-Cal en el futuro.

SI NO ESTA DE ACUERDO TIENE EL DERECHO A SOLICITAR UNA AUDIENCIA
Si no está de acuerdo con esta acción o si cree que hemos hecho un error, puede solicitar una audiencia. Si quiere mantener su Medi-Cal mientras apela, tiene que solicitar la audiencia antes que su Medi-Cal termine. Si no, solamente tiene 90 días para pedir la audiencia. Los 90 días comienzan el día que el condado le envió esta notificación. Por favor lea el reverso de esta notificación para aprender como solicitar una audiencia. <REGULATION> es la regulación en la cual nos basamos para esta decisión.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh
☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**
  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814
  OR
- **Call toll free:** **or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SU DERECHO A UNA AUDIENCIA

Usted tiene derecho a solicitar una audiencia si no está de acuerdo con cualquier acción que el Condado tome. Solamente tiene 90 días para solicitar una audiencia. Los 90 días comenzaron el día después de la fecha en que el Condado le dio o envió esta notificación. Si tiene un motivo justificado para no haber solicitado una audiencia antes de los 90 días, usted todavía puede solicitar una audiencia. Si proporciona un motivo justificado, es posible que todavía se programe una audiencia.

Si solicita una audiencia <u>antes</u> de que entre en vigor una acción en relación a la asistencia monetaria, Medi-Cal (Programa de Asistencia Médica de California), CalFresh, o cuidado de niños:

- Su asistencia monetaria/Medi-Cal no cambiará mientras espera a que se lleve a cabo la audiencia.
- Es posible que sus servicios de cuidado de niños no cambien mientras espera a que se lleve a cabo la audiencia.
- Sus beneficios de CalFresh no cambiarán mientras espera a que se lleve a cabo la audiencia o hasta el final de su período de certificación, lo que ocurra antes.

Si la decisión de la audiencia indica que estamos en lo correcto, usted nos deberá cualquier asistencia monetaria, beneficios de CalFresh o servicios de cuidado de niños que haya recibido de más. Para que reduzcamos o descontinuemos sus beneficios antes de la audiencia, marque a continuación:

Sí, reduzcan o descontinúen: ☐ Asistencia monetaria ☐ CalFresh ☐ Cuidado de niños

Mientras que espera la decisión de una audiencia relacionada a:

<u>Programa para la Transición de la Asistencia Pública al Trabajo *(Welfare to Work)*</u>:

No tiene que participar en las actividades.

Es posible que reciba pagos en relación al cuidado de niños para trabajar y participar en actividades aprobadas por el Condado antes de esta notificación.

Si le dijimos que los pagos para sus otros servicios de apoyo se iban a descontinuar, no recibirá más pagos, aunque participe en la actividad.

Si le dijimos que pagaríamos sus otros servicios de apoyo, se le pagarán de acuerdo a la cantidad y de la manera que le indicamos en esta notificación.

- Para recibir esos servicios de apoyo, tiene que participar en la actividad en que el Condado le pidió que participara.
- Si la cantidad que el Condado le paga para servicios de apoyo mientras que espera la decisión de la audiencia no es suficiente para que usted pueda participar, puede dejar de participar en la actividad.

<u>Cal-Learn (un programa de California para la educación de los padres adolescentes que reciben asistencia monetaria)</u>:

- No puede participar en el Programa de Cal-Learn si le dijimos que no le podemos asistir.
- Solamente pagaremos los servicios de apoyo de Cal-Learn si se trata de una actividad aprobada.

OTRA INFORMACIÓN

Miembros de planes de cuidado médico administrado de Medi-Cal: Es posible que la acción de esta notificación no le permita recibir servicios de su plan de salud de cuidado médico administrado. Puede comunicarse con la oficina de servicios de membresía de su plan de salud si tiene preguntas.

Mantenimiento de niños y/o en relación al cuidado de la salud: La oficina local de mantenimiento de hijos le ayudará gratuitamente a cobrar mantenimiento de hijos, aunque usted no esté recibiendo asistencia monetaria. Si ahora cobran mantenimiento de hijos para usted, continuarán haciéndolo a no ser que usted les pida por escrito que lo dejen de hacer. Le mandarán la cantidad actual de mantenimiento que se cobre pero se quedarán con los atrasos que se cobren que se le deban al Condado.

Planificación familiar: La oficina de bienestar público le dará información cuando usted la pida.

Expediente de audiencia: Si solicita una audiencia, la División de Audiencias con el Estado abrirá un expediente. Usted tiene derecho a ver este expediente antes de la audiencia y a recibir una copia de la declaración escrita de posición del Condado relacionada a su caso por lo menos dos días antes de la audiencia. Es posible que el Estado le dé el expediente de audiencia de usted al Departamento de Bienestar, y a los Departamentos de Salud y Servicios Humanos y de Agricultura de los Estados Unidos. **(Secciones 10850 y 10950 del Código de Bienestar Público e Instituciones - W&IC.)**

PARA SOLICITAR UNA AUDIENCIA:

- **Complete esta página.**
- Haga una copia de esta página y de la primera página para sus expedientes.
  Si la pide, su trabajador le dará una copia de esta página.
- **Envíe o lleve esta página a:**

  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814

  O fax a 1-916-651-2789
- **Llame gratuitamente al: 1-855-795-0634.** Las personas sordas/con problemas del habla que usan TDD* pueden llamar al **1-800-952-8349**.

Para obtener ayuda: Puede pedir información acerca de su derecho a una audiencia o sobre oficinas de asesoramiento legal llamando a los teléfonos estatales gratuitos mencionados arriba. Es posible que pueda recibir asesoramiento legal gratuito en la oficina local de asesoramiento legal o en la oficina de defensa de los derechos relacionados a la asistencia pública.

Si no quiere ir a la audiencia solo, puede llevar a un amigo o a otra persona con usted.

PETICIÓN PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción tomada por el Departamento de Bienestar Público del Condado de _____ acerca de mi(s):

☐ Asistencia monetaria ☐ CalFresh ☐ Medi-Cal

☐ Otro (anote)_____

La razón es la siguiente:_____

_____

_____

_____

_____

☐ **Si necesita más espacio, marque aquí y adjunte otra página.**

☐ Necesito que el Estado me proporcione un intérprete gratuitamente. (Un familiar o un amigo no puede actuar como intérprete de usted en la audiencia.)
Mi idioma o dialecto es el: _____

NOMBRE DE LA PERSONA A QUIEN LE NEGARON, CAMBIARON O DESCONTINUARON LOS BENEFICIOS	
FECHA DE NACIMIENTO	NÚMERO DE TELÉFONO
DIRECCIÓN: CALLE	
CIUDAD	ESTADO CÓDIGO POSTAL
FIRMA	FECHA
NOMBRE DE LA PERSONA QUE COMPLETA ESTE FORMULARIO	NÚMERO DE TELÉFONO

☐ **Quiero que la persona nombrada a continuación me represente en esta audiencia. Doy permiso para que esta persona vea mis expedientes o vaya a la audiencia por mí. (Esta persona <u>puede</u> ser un amigo o familiar, pero no puede actuar como su intérprete.)**

NOMBRE	NÚMERO DE TELÉFONO
DIRECCIÓN: CALLE	
CIUDAD	ESTADO CÓDIGO POSTAL

*TDD: aparato de telecomunicaciones para las personas sordas