**Family Medical Manual Notice #2**

# STATE OF COLORADO

*<Case Number>*
*<Client Name>*
*<Client Address 1>*
*<Client Address 2>*

*<Technician Name>*
*<County/MA Site>*
*<County Address 1>*
*<County Address 2>*
*<County Phone #>*

Date and time:
We did not get your documentation for proof of ☐ citizenship ☐ identification.

Your (application date) medical assistance application has been denied because you did not provide the documents. We needed this documentation to process your application.

Please call *<county/MA site worker>* at *<phone number>* with any questions you have about this letter. If there is a mistake in the information in this letter, please call me right away.

The back of this letter tells you what you can do if you disagree with this decision.

You may apply again at any time.

Thank you.

**YOUR RIGHT TO APPEAL**

## Medicaid Benefits:

If you think this action is wrong, you have the right to ask for a dispute resolution conference and/or a state hearing. If you think you need help, you may have a lawyer or any person you want help you. If your benefits are stopped or denied, you may apply for them again. If you want to appeal, see the directions and important time limits below.

**Dispute Resolution Conference** You can ask for an informal dispute resolution conference before going to a state hearing. If you want a dispute resolution conference, you must call or write your eligibility site worker right away. The name and phone number is on the other side of this notice.

**State Hearing** You can skip the dispute resolution and ask for a state hearing. You must ask for a state level hearing within **30 days** of the date of this notice if you disagree with this notice or disagree with the outcome of the dispute resolution process. To ask for a state hearing, sign and send this notice, OR write and send a letter to:

**Office of Administrative Courts**
**633 17th Street, Suite 1300, Denver CO 80202**

Be sure to keep a copy of this notice for yourself.

**If you write a letter asking for a dispute resolution conference and/or a state hearing, make sure you give: your name, social security number if you have one, daytime telephone number, mailing address, and why you want the conference and/or hearing.**

**Continued Benefits** If this notice says your benefits will stop and you want your benefits to continue, you must ask for a dispute resolution conference or a state hearing before the effective date of action shown on other side.

## For Child Health Plan *Plus* benefits:

If you have questions regarding this notice or your case, please contact CHP+ Customer Service at 1-800-359-1991. We have English and Spanish speakers to answer your calls or ask for the ATT Language Line service for help with all other languages. If you feel we were wrong, you have the right to ask for a review of our decision. Please send your request, in writing, within 30 days of the date of this notice, to:
**CHP+**
**PO Box 929**
**Denver, CO 80201**

**NON-DISCRIMINATION POLICY PLEASE READ**

If you think the county department or eligibility site has treated you differently because of race, color, sex, age, religion, political belief, national origin, or handicap, you have a right to complain to your County Department of Human Services or the State Department of Health Care Policy and Financing, 303.866.3513 or 1.800.221.3943. You can also write a letter of complaint to the Federal government at the following address:

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|---|---|
| U.S. Department of Health and Human Services<br>Office of Civil Rights<br>Regional Program Manager – Federal Office Bldg.<br>Federal Office Building<br>1961 Stout Street, 14th Floor, RM 1426<br>Denver, CO 80294<br>(303) 844-2024 | U.S. Department of Health and Human Services<br>Office of Civil Rights<br>200 Independence Ave., SM, RM 509F<br>Washington, DC 20201<br>(800)368-1019 |

If you have a qualifying disability, you may have rights under the Americans With Disabilities Act (ADA). Contact your county or Medicaid Application site for more information.

**If you are hearing impaired, call Relay Colorado at 1-800-659-3656.**