SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

NOTICE OF APPROVAL/DENIAL FOR MEDICAL ASSISTANCE/ OPTIONAL STATE SUPPLEMENTATION

From:

Date: _____

ID #: _____

To:

Applicant Name: _____

Your application for the following assistance has been: ☐ **APPROVED** ☐ **DENIED**

- ☐ ABD (Aged, Blind, Disabled)
- ☐ General Hospital
- ☐ HCBW (Home & Community Based Waiver Services)
- ☐ PCR (Parent / Caretaker Relative)
- ☐ PW (Pregnant Women & Infants)
- ☐ OSS (Optional State Supplementation)
- ☐ Pass Along
- ☐ SSI Retroactive Medicaid
- ☐ TEFRA (Katie Beckett)
- ☐ Title IVE/Regular Foster Care
- ☐ Other: _____

You have been approved for:

- ☐ A payment to a residential care facility on your behalf, effective _____. All of your monthly income, except $ _____ for your personal needs, must be paid to the facility.
- ☐ Medicaid coverage beginning _____. Your Medicaid card will be mailed to your current address. If you move, it is necessary that you notify your County Department of Health and Human Services because the post office is not permitted to forward Medicaid cards. You must present this card to the doctor, hospital, or drug store each time that you receive a medical service.
- ☐ Retroactive coverage, effective _____ through _____. This enrollment period has been added to the computer system. You will now be able to present your card to providers to verify your eligibility for this time period.
- ☐ Financially approved, pending: ☐ Admission to a nursing home or institution ☐ Level of Care ☐ PACE services ☐ Enrollment in waiver ☐ 30 consecutive days of service

Reason for Denial:

Manual/policy reference supporting this action:

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If your application was approved, you may have a choice about the way that you receive your Medicaid services. For more information, call 1-888-549-0820, toll-free.

☐ Fair Hearing:

If you would like to see if we can resolve any potential issues with this decision, please contact the Healthy Connections Member Contact Center at 888-549-0820 (TTY 888-842-3620). A representative will review your case. You have 30 days from the date of this notice to submit new information or submit any information that we previously requested.

You have the right to appeal this decision at a hearing, called a "fair hearing," with SCDHHS, the agency that administers Medicaid in South Carolina. You may represent yourself at the hearing, hire an attorney to help you or have someone speak on your behalf. In your fair hearing request, you should specifically state which issue(s) you wish to appeal and attach a copy of the notification received from SCDHHS regarding the specific matter on appeal. If you submit a fair hearing request within 10 days of the date on this notice, you may be eligible to continue to receive Medicaid benefits until a decision is made regarding the issue you seek to appeal. If you decide to continue receiving benefits during the fair hearing process, you may be asked to repay any charges to your Medicaid account if the decision is not in your favor.

You must submit a written request for a fair hearing no later than 30 calendar days from the date on this notice via one of the following methods:

- Online: www.scdhhs.gov/appeals
- Mail:
  SCDHHS – Central Mail
  PO Box 100101
  Columbia, SC 29202-3101
  Attn: Eligibility Appeals
- Fax: 888-835-2086
- Email: eligappeals@scdhhs.gov. For your privacy and security, please note that mailing personal health information is more secure than email.

You may request an expedited hearing if you feel that the standard fair hearing timeframe could jeopardize an individual's life, health, or ability to attain, maintain, or regain maximum function. Contact SCDHHS to make the request, state that you are requesting an expedited fair hearing, and explain why. If SCDHHS denies the request to expedite, the appeal will follow the standard 90-day timeframe.