STATE OF RHODE ISLAND P.O. BOX 8709

CRANSTON, RI 02920-8787

APPEAL INSTRUCTIONS

Deadlines

You must request your appeal within the number of days mentioned on your enclosed notice. If you miss this deadline, you may lose your right to appeal. After you have filed your appeal, we will schedule your hearing and issue a decision within 90 days, or 60 days if the hearing relates to your SNAP benefits. A decision will issue on all HealthSource RI appeals within 90 days of the date an appeal request is received, as administratively feasible.

Expedited Appeals

You have the right to an expedited appeal if you have an immediate need for health services or SNAP benefits and waiting for a standard appeal could seriously jeopardize your life or health, or ability to attain, maintain, or regain maximum function. We must decide expedited appeals as quickly as possible, given the circumstances. If we deny your request for an expedited appeal, we must inform you quickly, and we must handle your appeal through our standard process.

Right to Continue Benefits While Awaiting Hearing

You may have the right to have your benefits continue unchanged while you wait for your hearing (this is called "Aid-Pending"). You can only request Aid-Pending if you appeal within 10 days after you receive the notice you are challenging, unless you are appealing an eligibility redetermination made by HealthSource RI. For HealthSource RI, Aid-Pending is only available if you are appealing an eligibility redetermination that occurred within 30 days of the date you file your appeal, and the request is made by telephone to HealthSource RI at 1-855-840-HSRI (4774). Unless you can show otherwise, for Medicaid and HealthSource RI, we will assume that you received the notice 5 days after the date on the notice. If you pay monthly premiums, you must still pay those premiums during the Aid-Pending period. If you have Medicaid and you receive Aid-Pending, and then you lose your appeal, the State may make you pay back its costs for covering you during the Aid-Pending period. If you are receiving tax credits to help pay for your premiums and you receive Aid-Pending, and then you lose your appeal, then you may owe extra money in your federal taxes next year. If you receive SNAP, RIW or GPA benefits and receive Aid-pending, and then you lose your appeal, you may need to pay back the benefits you were issued but were not entitled to during this period.

Right to Represent Yourself and Right to be Represented

You have the right to represent yourself at the hearing, or to be represented by anyone you choose, including an attorney, advocate, friend, or relative.

Legal advice is available from Rhode Island Legal Services, Inc. at 274-2652 or 1-800-662-5034. If you choose to have Legal representation, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the Legal representative access to the Agency case record. It is also needed for the Hearing Office to confirm the representation for purposes of follow-up, review, request for continuances, etc.

For More information visit www.healthyrhode.ri.gov
Para mais informações visite www.healthyrhode.ri.gov

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Eligibility of Other Household Members May be Effected

Our appeal decision may result in changes to the eligibility of another member of your household.

Access to Your Case Record

You have the right to see your case record, including any evidence the State will use at your hearing. To view your case record, call us at 1-855-MYRIDHS (1-855-697-4347). If you are appealing an action taken by HealthSource RI, you may request a copy of your record by calling: 1-855-840-HSRI (4774).

Informal Resolution

We may be able to fix your problem quickly without a hearing. Please call 1-855-MYRIDHS (1-855-697-4347) so that we can review your case informally. If you are appealing an action taken by HealthSource RI, you may contact HealthSource RI at 1-855-840-HSRI (4774) to request an informal review of your appeal. We will reach out to you in an effort to resolve your appeal informally. Your right to a hearing will not be impacted by efforts to resolve your issue informally.

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APPEAL FORM

Appeal Request Process

You may request an appeal by doing one of the following below. If you submit this form, the state will complete a review of your case to try to resolve the issue.

- Online. Log into your account at www.healthyrhode.ri.gov and click on "file an appeal".
- **By phone.** You can file an appeal regarding Medicaid and Private Health Coverage through HealthSource RI by calling HealthSource RI at 1-855-840-HSRI (4774). For questions about filing an appeal for human services programs such as SNAP, RIW, Child Care, GPA, or SSP call the Department of Human Services at 1-855-MY-RI-DHS (1-855-697-4347).
- In person. For in-person assistance visit www.dhs.ri.gov to view office locations.
- By mail. Complete this form and mail it to ATTN: Appeals STATE OF RHODE ISLAND, P.O. BOX 8709, CRANSTON, RI 02920-8787.

Name (required):		
Date of Birth (required):		
Account Number:		
Address (required):		
Phone number:		
Email:		
Do you need help speaking, reading or writing Eng	lish?	
If yes, what is your primary language?		
Preferred method of contact (circle one): email / p	paper mail	
You must check off the reason(s) for your appeal:		
Health Coverage:	Human Services:	
Medicaid	SNAP	GPA
Private Plan - HealthSource RI	RIW	CHILD CARE
Both/Unsure	SSP	
Other (Please ex	plain)	

Please explain the reason	for your appeal:		
Do you need important he appeal? Yes No:	alth services or SNA	P benefits immediately? If so, would you li	ke an expedited
If yes, Please explain:			
ASSISTANCE A ☐ Check this box if som	ND/OR SNAP BEN eone is going to he	MY FAVOR, I UNDERSTAND THAT I MU EFITS FOR WHICH I AM DETERMINED II	NELIGIBLE during the appeals
Name:	ttorney, friend, or fan	nily member. Provide this person's contact	information:
Phone:			=
Address:			_
Email:			_
Would you like your cov decision? ☐ Yes ☐ N	_	to continue unchanged while you wait f	or a hearing
Signature		Date	
	Recipient)	-	
TO BE COMPLETED BY	THE AGENCY ONL	Y :	
APPEAL IS ABOUT:	RIW	MEDICAID	GPA
	SNAP	PRIVATE HEALTH PLAN	CHILD CARE
		OTHER	
Indicate Specific Policy Ma	anual Reference:	Section(s)	
Agency response to appear	al/explanation:		
Agency Representative (S	ignature)	Supervisor(Signature)	
(Print Name)		(Print Name)	
Local Office			

For More information visit <u>www.healthyrhode.ri.gov</u>

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