

MC+ ADVANCE ACTION NOTICE

**PURPOSE:** To provide official notice of the intent to discontinue or change MC+ healthcare coverage unless the customer requests a hearing within TEN calendar days after the date of this form. This form advises the customer of the right to a hearing and the form includes the reason for the decision.

**NUMBER OF COPIES AND DISPOSITION:** Make two copies. Mail the original to the customer and file the other copy in the case record.

**MANUAL REFERENCE:** Chapter I and X - Income Maintenance Manual

**INSTRUCTIONS FOR COMPLETION:** This form may be written legibly in ink or typed.

Complete, Date, Case Name, and Address in the **"TO"** and **"FROM"** boxes. Date should be the date mailed.

Check the appropriate box to indicate what action is to be taken and in the blank spaces, complete the appropriate entries:

**"Discontinue MC+ healthcare coverage for":** Enter the name or names of person/s no longer eligible for MC+.

**"The last day of MC+ healthcare coverage is":** Use the last day of MC+ coverage.

**"Require you to pay a premium to continue to receive MC+ healthcare coverage for":** Enter the name or names of person/s who are eligible for LOC 3.

**"The premium amount will be based on your family size of":** Enter the number in the assistance group (Field 29 of IMU5) **"and month income of"** enter the gross monthly income from Field 41 of IMU5.

**"The reason for this proposed change is that":** This area MUST be completed on each form. Enter an explanation to the customer in understandable language which includes:

- The change in the customer's circumstances which resulted in the proposed action.
- The eligibility factor involved; and
- Reference to the specific law, rule, regulation, or manual reference on which the decision is based. (A manual reference should be used only if no law or regulation is applicable.)

**"If you believe this decision is wrong, you have until":** Enter the day of the week, the month, date, and year upon which the customer's right to request a hearing expires. Determine the date by counting ten calendar days after the date shown at the top of the letter.

**"To request a hearing by telephone call":**

Enter the phone number of the local Division of Family Services office.

**"For the possibility of free legal service call":** If Legal Services are available in your area, enter the telephone number. If not available, leave blank.

**Tear-Off Section:**

This section is for the customer to request a hearing in writing.

**"If you want a hearing, fill out this form, tear it off and mail it to":** Enter the MC+ Service Center and the DFS office address.

**FOR OFFICE USE ONLY:** Enter the case DCN, MC+ Service Representative's (caseworker) name, load number and the date the form was mailed to the customer. Complete these spaces prior to mailing the form. When the "tear-off" is returned, the date it is received must be entered in the space provided.