

TRANSPORTATION ASSESSMENT NOTIFICATION

Date Mailed: _____

Dear _____

Your request on _____ for assistance with transportation for
(date)

[Medicaid recipient(s)]

[Medicaid recipient(s)]

to medical appointments and other Medicaid covered services has been:

Approved from _____ **through** _____.

Please read the enclosed documents for instructions on requesting transportation trips, the “No Show” and conduct policies.

Denied

Explanation: _____

HEARING RIGHTS: If you disagree with this decision, you have a right to a hearing to review the county’s action. Call your worker at the number below within 60 days to ask for a hearing. The 60th day is _____. If you do not ask for a hearing by this day, you cannot have a hearing unless you have good cause for missing the deadline. You may request medical transportation at any time.

Worker: _____

Phone Number: _____

PLEASE CONTINUE READING FOR IMPORTANT INFORMATION ABOUT YOUR RIGHT TO A HEARING.

Do you disagree with the decision? You can ask for a hearing.

If you think we are wrong in denying your request for medical transportation, you have the right to a hearing. You must ask for this hearing within 60 days (or 90 days if you have good cause for delay). The hearing will be to meet and review your situation and provide you with transportation services if the decision on your request was wrong.

Contact your local Department of Social Services to ask for a hearing. A local hearing will be held within 5 days of your request unless you ask for it to be postponed. The hearing can be postponed (for a good cause), for as much as 10 calendar days. If you think the decision of the local hearing is wrong, contact your local Department of Social Services **WITHIN 15 DAYS** of receiving the decision of the local hearing to ask for a state hearing.

You have the right to be represented.

You may have someone speak for you at the hearing, such as a relative or a paralegal or an attorney obtained at your expense. Free legal services may be available in your community. Contact your nearest Legal Aid or Legal Services Office, or call 1-866-219-5262 toll-free.

Do you understand your rights or have other questions?

Do you understand how to get a hearing? If you have any questions, please contact your local Department of Social Services as soon as possible.

Also, you may call the DHHS Customer Service Center, toll-free at 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (Note: this is a TTY number that is only answered for deaf or hearing impaired callers). The DHHS Customer Service Center is open from 8:00 a.m. until 5:00 p.m., Monday through Friday.

You also have responsibilities.

1. You will need to complete a transportation assessment at each Medicaid application, review, or when you experience a change, to continue receiving transportation assistance.
2. You must report all changes (for example, change in income or resources, family members in the household, change of address) to your Medicaid caseworker at your local Department of Social Services within 10 days of the change. If you do not know if a change is important, ask your caseworker.