Georgia Department of Human Services
Division of Family and Children Services
Notification of Deduction of Medical Expense

_____ Date _____

_____

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_____

Dear _____,

You have requested a deduction from the amount you owe the nursing home/EDWP (formerly Community Care)/Hospice provider for the following medical expenses:

_____

_____

_____

_____

The expense is not an allowable deduction and, therefore, it will not reduce your patient liability/cost share. The expense is not an allowable deduction for the following reason:

_____ Verification was not received in time.

_____ This service or item is Medicaid reimbursable and, therefore, is not an allowable deduction.

_____ This service or item is not on the list of allowable deductions issued by the Department of Community Health (DCH).

_____ Other _____

_____

_____

If you do not agree with any action taken on your Medicaid case, you have the right to ask for a fair hearing before a state hearing officer. You may be represented at the hearing by a lawyer, relative, friend or anyone you choose. If you want a hearing on your Medicaid case you must ask for the hearing in writing within thirty (30) days from the date of this notice.

FAIRHEARING REQUEST

Complete and return this form if you do not agree with this decision.

Today's Date:	**Telephone No.** (Where You can be Reached)

I am requesting a fair hearing for: **o Medical Assistance**

By checking this box, I understand I am requesting a fair hearing because I disagree with the decision made on my request for **SNAP/Senior SNAP**, Medicaid, TANF, or WIC. I understand an administrative law judge will listen to the cases presented by both parties and will determine if state and federal law was followed correctly.

Please tell us why you want a fair hearing:

Check the correct box if applicable:

o I do not want to continue receiving the benefits I now receive while waiting for the hearing decision.

o I want to continue receiving the benefits I now receive while waiting for the decision.
I understand that I will be required to repay the Department of Human Services any overpayment in benefits to which I was not entitled as determined by the hearing official. I understand that my benefits may not be continued if my case closed at the end of a period of eligibility or if my application to receive benefits was denied.

_____ _____

Signature or Mark of Claimant Date

Please return this completed form to your County Department of Family and Children Services

You may be able to get legal help at no cost. If you want a lawyer to help you, you may call one of the numbers below.

1. Georgia Legal Services Program
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. Office of the State Long-Term Care Ombudsman
   Division of Aging Services
   [LTC_DAS_Address]
   [LTC_DAS_Number]

3. Atlanta Legal Aid
   404-377-0701 (DeKalb County)
   678-407-6469 (Gwinnett County)
   770-528-2565 (Cobb County)
   404-524-5811 (Fulton County)
   404-669-0233 (So Fulton/Clayton County)

4. Georgia Senior Legal Hotline
   1-888-257-9519
   (Statewide legal services for elderly persons)