ARIZONA DEPARTMENT OF ECONOMIC SECURITY (DES)
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM(AHCCCS)

CUSTOMER:	DATE:	HEAPLUS PERSON ID:	APPLICATION ID:
AMBER ROSE ATTEBERY	12/26/2022	39903981220171	2022359007020

AMBER ROSE ATTEBERY
PO BOX 164
CONCHO AZ 85924-0174

OTHER IDS USED BY AHCCCS OR DES
AHCCCS ID : A02500293
AZTECS Case ID : 04230911
Call 1-855-HEA-PLUS (432-7587) if you have any questions or need help.

Decision About Benefits And Services

Dear Amber Rose Attebery

Please read this entire letter.

This letter tells you about:

- The decisions we made for the programs you applied for or are getting now.
- Additional actions you may be required to take.
- How to use your benefits and services, if approved.
- Your rights and responsibilities.
- Other services that may be available to you.

AHCCCS Medical Assistance

MEDICAL ASSISTANCE - NO CHANGE: We received information about a recent change to your case. The new information does not change medical coverage for:

- Amber Rose Attebery (Birthdate: 06/09/1987; Person ID: 39903981220171; AHCCCS ID: A02500293) in the Caretaker category.
- Raymond Allen Lee Attebery (Birthdate: 08/21/2008; Person ID: 39903600221170; AHCCCS ID: A02500291) in the Children category.
- Brooklyn Paige Johnson (Birthdate: 11/22/2015; Person ID: 39903601221179; AHCCCS ID: A02500159) in the Children category.

The Children group is the Medicaid category for children age 18 and younger.

The Caretaker group is the Medicaid category for adults with dependent children.

AHCCCS Medical Assistance

What You Need To Know

Renewing

We will let you know when it is time to renew your coverage and what you need to do.

Responsibility For Reporting Changes

You must report any of the following changes to us for anyone in the home:

- Income
- Address or phone number
- Someone moves in or out of the home
- Someone moves out of Arizona
- Someone becomes an inmate of a public institution (jail, prison)
- Marriage, divorce, or separation
- Health insurance coverage (other than AHCCCS)
- Birth, or death

You must report the change within 10 days of it becoming known to you. If you do not report changes, it

may be considered fraud and could result in penalties.

Legal Authorities for This Decision

The laws, rules, and regulations we used to make this decision are:

Children's Group Approval
42 CFR 435.118; 42 CFR 435.603; 42 USC 1396(a)(10)(A)(i)(III), (IV), (VI), and (VII); AAC R9-22-1420 and 1427

Parent/Caretaker Relative Approval
42 CFR 435.110; 42 CFR 435.4; 42 CFR 435.603; 42 USC 1396u-1; AAC R9-22-1420 and 1427

You can find these laws at a public library or on the Internet at:
United States Code (USC): **www.gpo.gov/fdsys/**
Code Of Federal Regulations (CFR): **www.gpo.gov/fdsys/**
Arizona Revised Statues (ARS): **www.azleg.gov/arizonarevisedstatutes.asp**
Arizona Administrative Code (AAC): **www.azsos.gov/public_services/table_of_contents.htm**

Quality Review

Cases are randomly selected for quality control review. If your case is selected, you may be contacted to give us more information. If you are getting coverage or are applying and you do not cooperate with the review, your benefits or coverage may stop or a decision will not be made until you cooperate.

Website

Log in at https://www.healthearizonaplus.gov where you can:

- Tell us about your changes
- See your application/case status
- See your benefit amounts and coverage
- See letters and important information
- Manage your account
- Renew your benefits and coverage

What if you don't understand this letter?

If you have questions about this letter or need help, call the Health-e-Arizona Plus Customer Support Center at 1-855-HEA-PLUS (432-7587). For the hearing impaired call TTY/TDD: 7-1-1.

What If You Do Not Agree With Our Decision?

Your Appeal Rights

You have the right to request an appeal if you do not agree with our decision. When you request an appeal you have the right to:

- Be represented by a lawyer or a person you have authorized.
- Meet with us before your hearing to discuss your case (we may be able to fix the problem at the meeting).
- Get a copy of the law, rule, or policy that we used to make our decision.
- Review, obtain, or a copy of the case record necessary for proper presentation of your case.
- Examine documents to be used by the state at the hearing.
- Bring witnesses to the hearing.
- Establish all pertinent facts and circumstances.
- Present an argument without undue interference.
- Question any testimony or evidence including the opportunity to confront or cross-examine adverse witnesses.
- Present additional documents and testimony at the hearing.
- Have an interpreter provided if you do not speak English, are deaf, or are mute. The Office of Administrative Hearings or Office of Appeals needs to be notified in writing at least 10 days in advance of the hearing date or your hearing may be delayed.
- Bring an interpreter to the hearing.

Even if you already have a pending appeal about another decision, you may file another appeal request about the decision on this letter.

How to Request an Appeal

You may request an appeal using one of the following options:

- **Recommended:** Go to www.healthearizonaplus.gov to log in to your Health-e-Arizona Plus account and complete an appeal request form online. If you do not have a Health-e-Arizona Plus account

already, see the "Website" section in this letter for help creating one.
- Call us at (855) HEA-PLUS (432-7587) to ask for an appeal;
- Fill out the Appeal Request form at the end of this section and give it to us.
- Get an appeal form at an eligibility office
- Write your request for an appeal on a separate piece of paper. Please include all of the following information:

  - Tell us which program decision(s) you are appealing (Medical, Cash, and/or Nutrition Assistance),
  - Date of the decision letter you disagree with,
  - Your name,
  - Date of birth,
  - Write this ID#: 2022359007020
  - Social Security Number,
  - Mailing address and phone number,
  - Reason you do not agree with our decision(s),
  - The name of the person you are authorizing to represent you at the hearing, if you have one;
  - You or your representative's printed name, signature, and date.

Important Dates

If you are appealing a Medical Assistance or long term care decision, the deadline to submit your appeal request is 01/31/2023.

Legal Help with the appeal process

For free legal advice:
- In Maricopa County, Mohave County, Yavapai County and Yuma County contact Community Legal Services (www.clsaz.org) at 1-800-852-9075;
- In Pima County, Pinal County, Cochise County and Santa Cruz County contact Southern Arizona Legal Aid (www.sazlegalaid.org) at 1-800-640-9465;
- In Coconino County contact DNA-People's Legal Services (www.dnalegalservices.org) at 1-800-789-5781.

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APPEAL REQUEST FORM

Instructions: You may use this form to ask for an appeal if you can't submit your request through www.healthearizonaplus.gov. This form should only be used to ask for an appeal. Please do not use this form if you only want to report a change. To find out how to report a change you can call (855) HEA-PLUS (432-7587).

You can give this form to us:

In Person: Call us at 1-855-HEA-PLUS to find an eligibility office		**By Mail:** **Department of Economic Security** **ATTN: Appeals** **P.O. Box 19009** **Phoenix, AZ 85005-9009**

Personal Information	**Application ID: 2022359007020**
Customer's Name: Amber Rose Attebery	**Phone Number:** **5202652345**
Customer's Address: Po Box 164 Concho, AZ 85924-0174	***Is this the address and phone number the customer wants to use for the appeal request?*** □ Yes □ No – Please give us the address and phone number to use for the appeal request:

Does this person need an interpreter? □ No □ Yes - What language?

_____

Does this person need assistance because of a disability? □ No □ Yes - Explain:

_____

Representative's Information

Complete this section if you would like another person to represent you at your Hearing. This does not have to be your authorized representative.

Representative's Name: (*Please print.*)	**Address:**

Phone Number:	

Does this person need an interpreter? □ No □ Yes - What language?

_____

Does this person need assistance because of a disability? □ No □ Yes - Explain:

_____

Decision(s) You Are Appealing

Check which decisions you want to appeal and tell us why you want a hearing.

Which decision(s) are you requesting an appeal for?	**Tell us why you want an appeal:**
□ Medical Assistance	

Option to request an expedited appeal for Medical Assistance decisions.

You can request to have an expedited appeal for Medical Assistance, Medicare Savings Program, or the Arizona Long Term Care System. If you do not request an expedited appeal for Medical Assistance decisions or if you are not granted an expedited appeal, the agency is required to make a final decision within 90 days. Your request for an expedited appeal for Medical Assistance decisions will be reviewed to determine if you meet the requirements.

To be approved for an expedited appeal you must give us a signed statement from a medical provider at the same time you submit the appeal request. The statement must include **all of the following**:

- The customer has a procedure or treatment scheduled, or the individual is unable to schedule a procedure or treatment due to the lack of coverage;
- The customer does not currently have health insurance that will cover most of the cost of a treatment; and
- The customer's health or ability to reach, keep, or regain full functionality will be put at risk if the customer has to delay a procedure or treatment for 90 days or less from the date of the appeal request.

The statement from the medical provider must be submitted with this appeal request. If you submit a request for an expedited appeal and you do not submit a statement that meets all the criteria above, your request for an expedited appeal will be denied.

Are you wanting to expedite an appeal for Medical Assistance, Medicare Savings Program or for the Arizona Long Term Care System?

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□ Yes, I want to expedite the appeal

□ No, I do not want to expedite the appeal

Sign and Date

I have been advised of my rights concerning my fair hearing.

Your signature or the signature of your representative:	Signature is that of the:	Date:
	□ Customer □ Representative	