Medicaid and CHIP MAC Learning Collaboratives

ELIGIBILITY-RELATED DETERMINATION NOTICES STATE TOOLKIT
Tool #2: Key Messages Menu Set

The Coverage Learning Collaborative Notices Project team (CMCS, Manatt Health Solution, Maximus Center for Health Literacy) developed a master list of notice snippets, which are a collection of many of the different messages that could be included in eligibility-related determination notices. While the list is not exhaustive, we reflected a wide range of key messages (e.g., process updates, eligibility determinations, appeals, information for special populations, rights and responsibilities). The team focused on the development of number of Medicaid/CHIP-related messages. The messages not developed, including several Marketplace-related messages, are distinguished as gray rows in the menu.

Medicaid/CHIP-related messages were crafted by consumer literacy experts, reviewed by the policy team, tested with consumers, and revised based on feedback from consumer testing, consumer advocates, and states.

- **Coding:** Messages are labeled and coded for quick reference and are accompanied by a description of the message content and drafted consumer message. This is the "Key Message Code" referenced in *Tool #3: Notices Content Templates*.
- **Legal requirements:** Content in **red and bold** under the "Content Description" heading indicates information legally required by federal statute and final and proposed regulations.
- **Consumer-specific content**: We assume that states will have the capacity to customize notices for individuals based on computerized data elements. We have flagged where variable text may be inserted through **<variable text>.**
- **State-specific content:** We assume that states will have the capacity to customize notices for state policies and processes. We have flagged where this information may be inserted through **[state-specific content].**

Notice Segment		Content Description	Key Message
A. Additional Information / Reminders			
1.	***Request for Additional Information – Inconsistent information and not reasonably compatible***		
a.	Income	▪ Explanation that income information is inconsistent with records.	We reviewed your application for **[State Medicaid program]** health coverage. What you told us about your income does not match our records. We need more information.
b.	Citizenship	▪ Explanation that citizenship information is inconsistent with records.	What you told us about your citizenship does not match our records.
c.	Residency	▪ Explanation that residency information is inconsistent with records.	We reviewed your application for **[State Medicaid program]** health coverage. What you told us about your residency does not match our records. We need more information.
d.	SSN	▪ Explanation that SSN information is inconsistent with records.	We reviewed your application for **[State Medicaid program]** health coverage. What you told us about your

Notice Segment		Content Description	Key Message
			Social Security number does not match our records. We need more information.
2.	***Resolve Inconsistency through Documentation and Types of Acceptable Documents*** *– Need various configurations depending on eligibility criteria and State verification plan*		
a.	Income	▪ **Requirement that consumer must provide acceptable documentation in order to resolve inconsistency.** ▪ List of sample documentation ▪ Contact information for consumer to receive information about exemptions from submitting additional documentation and special circumstances under which an individual may be exempt.	Give us a copy of one of these documents: o Your pay stubs for the last month o Your most recent tax return, unless you think your tax return will be different this year o A letter from your employer telling us your income Please keep your original document and give us a copy. Please write your letter number (**<letter number>**) on the copy before you give it to us. If you do not have one of these documents, read the list that came with this letter. It has other documents you can use. If you need help, please call us at **[phone number]** (**TTY: [TTY phone number]**).
b.	Citizenship	▪ **Requirement that consumer must provide acceptable documentation in order to resolve inconsistency.** ▪ List of sample documentation ▪ Contact information for consumer to receive information about exemptions from submitting additional documentation and special circumstances under which an individual may be exempt.	Please give us a copy of one of these documents: o Your United States passport o Your citizenship or naturalization certificate o Papers that show you are a member of a tribe o Your birth certificate and driver's license Please keep your original document and give us a copy. Please write your letter number (**<letter number>**) on the copy before you give it to us. If you do not have one of these documents, read the list that came with this letter. It has other documents you can use. If you need help, please call us at **[phone number]** (TTY: **[TTY phone number]**).
c.	Residency	▪ **Requirement that consumer must provide acceptable documentation in order to resolve inconsistency.**	

Notice Segment		Content Description	Key Message
		▪ List of sample documentation ▪ Contact information for consumer to receive information about exemptions from submitting additional documentation and special circumstances under which an individual may be exempt.	
d.	SSN	▪ **Requirement that consumer must provide acceptable documentation in order to resolve inconsistency.** ▪ List of sample documentation ▪ Contact information for consumer to receive information about exemptions from submitting additional documentation and special circumstances under which an individual may be exempt.	
3.	***How to Submit Documentation to Resolve Inconsistency***		
a.	Medicaid	▪ **Instructions for submitting documentation.**	1. Online. Go to **[website address]** and follow the website directions to upload a copy. 2. By fax. Fax a copy to us at: **[fax number]**. 3. By mail. Send a copy to us at: **[State Medicaid program]** address]. 4. In person. Bring a copy to us **[in-person location access]**.
b.	CHIP	▪ **Instructions for submitting documentation.**	1. Online. Go to **[website address]** and follow the website directions to upload a copy. 2. By fax. Fax a copy to us at: **[fax number]**. 3. By mail. Send a copy to us at: **[State CHIP program] address]**. 4. In person. Bring a copy to us **[in-person location access]**.
c.	APTC/CSR/QHP		

Notice Segment		Content Description	Key Message
4.	Reminder to resolve income inconsistency before expiration of "reasonable period" (Medicaid/CHIP)	▪ Notification that eligibility determination cannot be made until additional information is provided.	If you do not give us proof of your income, we cannot finish reviewing your application for health coverage, and your application will be denied.
5.	Reminder to resolve inconsistency before expiration of "reasonable opportunity" (Marketplace)		
6.	Reminder to send documentation; otherwise, coverage will end.	▪ **Notification that consumer has set number of days to submit documentation in order to be considered for Medicaid eligibility.**	Please give us proof of your citizenship by **<coverage end date>** or your health coverage will end.
B. Eligibility Determination			
1.	***Medicaid Determination***		
a.	Individual: Eligible for Medicaid	▪ **Decision on application**	Good news for you! You qualify for **[State Medicaid program]** health coverage.
b.	All Family Members: Eligible for Medicaid	▪ **Decision on application**	Good news for you, **<Person 1, Person 2, etc>**! You qualify for **[State Medicaid program]** health coverage.
c.	Mixed Coverage Family: Eligible for Medicaid	▪ **Decision on application**	Good news for **<Person 1, Person 2, etc>**! They qualify for **[State Medicaid program]** health coverage.
d.	Individual: Eligible for Emergency Medicaid	▪ **Decision on application**	You qualify for limited **[State Medicaid program]** health coverage. This means you only get health coverage if you have an emergency.
e.	Ineligible for Medicaid	▪ **Decision on application**	We reviewed your application. We decided that you do not qualify for **[State Medicaid program]** health coverage.
f.	Summary of Temporary Medicaid Eligibility and Request for Additional Information	▪ **Decision on application**	There are two important pieces of news for you in this letter: 1. For now, you have **[State Medicaid program]** health coverage. 2. But, you need to give us more information to keep your coverage.

Notice Segment		Content Description	Key Message
g.	Individual: Eligible for Medicaid; Ineligible for APTC/CSR	▪ **Ineligibility for APTC due to minimum essential coverage**	Because you qualify for **[State Medicaid program]**, you will get coverage without needing to buy health insurance. This means you do not get help paying for health insurance through the new Health Insurance Marketplace. **[State Medicaid program]** health coverage offers services at a much lower cost to you.
h.	All Family Members: Eligible for Medicaid; Ineligible for APTC/CSR	▪ **Ineligibility for APTC due to minimum essential coverage**	Because you, **<Person 1, Person 2, etc.>** qualify for **[State Medicaid program]**, you get coverage without needing to buy health insurance. This means you do not get help paying for health insurance through the new Health Insurance Marketplace. **[State Medicaid program]** health coverage offers services at a much lower cost to you.
i.	Mixed Coverage Family: Children Eligible for Medicaid; Ineligible for APTC/CSR	▪ **Ineligibility for APTC due to minimum essential coverage**	Because **<Person 1, Person 2, etc.>** qualify for **[State Medicaid program]**, they get coverage without needing to buy health insurance for them. This means you do not get help paying for their health insurance through the new Health Insurance Marketplace. **[State Medicaid program]** health coverage offers services at a much lower cost to you.
j.	Medically needy eligibility		
2.	***Medicaid Eligibility Basis***		
a.	Individual: Basis for eligibility determination for Medicaid (approval)	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and information we got from other data sources. We found that your household size is **<applicant's household size> <person/people>** and your income is $**<applicant's monthly income>** each month. Since your monthly income is below the **[State Medicaid program]** income **<limit/limits>**, you qualify.
b.	Mixed Coverage Family: Basis for children's eligibility determination for Medicaid (approval)	▪ **Basis of eligibility determination**	We counted their household size and income based on what you told us on your application and information we got from other data sources. We found that their household size is **<applicant's household size>**

Notice Segment		Content Description	Key Message
			<person/people> and their household income is **$<applicant's monthly income>** each month. Since their household monthly income is below the **[State Medicaid program]** income <**limit/limits>** for children, **<Person 1, Person 2, etc.>** qualify.
c.	Basis for eligibility determination for Medicaid – eligible during reasonable opportunity period to resolve citizenship/immigration status	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and information we got from other data sources. We found that your household size is **<applicant's household size> <person/people>** and your income is $**<applicant's monthly income>** each month. Since your monthly income is below the **[State Medicaid program]** income **<limit/limits>**, you qualify based on your income. But, what you told us about your citizenship does not match our records. You still need to give us proof of your citizenship to keep your health coverage.
d.	Basis for eligibility determination for Emergency Medicaid	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and information we got from other data sources. We found that your household size is **<applicant's household size> <person/people>** and your income is $**<applicant's monthly income>** each month. Since your monthly income is below the **[State Medicaid program]** income **<limit/limits>**, you qualify based on income. But, our records show that you have not had qualifying immigration status for five years or more. So you only qualify for limited **[State Medicaid program]** health coverage.
e.	Individual/ All Family Members: Basis for ineligibility determination for Medicaid (denial)	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and information we got from other data sources. Your household size is **<applicant's household size> <person/people>** and your income is **$<applicant's monthly income>** each month.

Notice Segment		Content Description	Key Message
			The **[State Medicaid program]** income **<limit/limits>** for your household size is $**<income limit dollar amount>** each month. Since your monthly income is above the **[State Medicaid program] <income limit/limits>**, you do not qualify for **[State Medicaid program]** health coverage. If you think we made a mistake, you can appeal. See the next page for more information.
f.	Mixed Coverage Family: Basis for children's ineligibility determination for Medicaid (denial)	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and information we got from other data sources. Your household size is **<applicant's household size> <person/people>** and your income is $**<applicant's monthly income>** each month. The **[State Medicaid program]** income **<limit/limits>** for your household size is $**<income limit dollar amount>** each month. Since your monthly income is above the **[State Medicaid program]** income **<limit/limits>** for children, **<Person 1, Person 2, etc.>** do not qualify for **[State Medicaid program]** health coverage. If you think we made a mistake, you can appeal. See the next page for more information.
g.	Individual: Basis for eligibility determination for 5 year bar	▪ **Basis of eligibility determination**	To get full **[State Medicaid program]** health coverage, you must: o Be a citizen of the United States, or o Have qualifying immigration status for five years or more. To learn more, call us at **[phone number]** (TTY: **[TTY phone number]**) or go to website **[website address]**.
h.	All Family Members: Basis for eligibility determination for Medicaid (approval)	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and information we got from other data sources. We found that your household size is **<applicant's household size>** person/people and your income is $**<applicant's monthly income>** each month. Since your monthly income is below

Notice Segment		Content Description	Key Message
			the **[State Medicaid program]** income limit/limits, you, **<Person 1, Person 2, etc.>** qualify.
i.	CHIP Eligible Children in Separate CHIP State: Basis for Screened Ineligible for Medicaid	▪ **Screening for Medicaid**	Medicaid is a health coverage program for people with lower incomes. The Medicaid income limit for children for your household size is $**<applicant's monthly income>** each month. Since your income is above the limit, we do not think **<Person 1>** qualifies for **[State Medicaid program]** health coverage. Medicaid health coverage offers more health services and lower costs. But only the State Medicaid Agency can decide if he/she qualifies. If you would like to see for certain if he/she qualify, you can ask for a review. See the next page to learn more.
j.	CHIP Eligible Children in Separate CHIP State: Basis for Screened Ineligible for Medicaid	▪ **Screening for Medicaid**	Medicaid is a health coverage program for people with lower incomes. The Medicaid income limit for children for your household size is $**<applicant's monthly income>** each month. Since your income is above the limit, we do not think **<Person 1, Person 2, etc.>** qualify for **[State Medicaid program]** health coverage. Medicaid health coverage offers more health services and lower costs. But only the State Medicaid Agency can decide if they qualify. If you would like to see for certain if they qualify, you can ask for a review. See the next page to learn more.
3.	***CHIP Determination***		
a.	Individual: Eligible for CHIP	▪ **Decision on application**	Good news for **<Person 1>.** He/She qualifies for **[State CHIP program]** health coverage.
b.	Mixed Coverage Family: Eligible for CHIP	▪ **Decision on application**	Good news for **<Person 1, Person 2, etc.>**. They qualify for **[State CHIP program]** health coverage.
c.	Individual: Ineligible for CHIP	▪ **Decision on application**	We reviewed your application. We decided that **<Person 1> does not** qualify for **[State CHIP program]** health coverage.
d.	Children/Mixed Coverage: Ineligible for CHIP	▪ **Decision on application**	We reviewed your application. We decided that **<Person 1, Person 2, etc> do not** qualify for **[State CHIP program]** health coverage.

Notice Segment		Content Description	Key Message
e.	Summary of Temporary Medicaid Eligibility and Request for Additional Information	▪ **Decision on application**	There are two important pieces of news for you in this letter: 1. For now, you have **[State CHIP program]** health coverage. 2. But, you need to give us more information to keep your coverage.
f.	Eligible for CHIP but subject to waiting period		
g.	Individual: Eligible for CHIP; Ineligible for APTC/CSR	▪ **Ineligibility for APTC due to minimum essential coverage**	Because you qualify for **[State CHIP program]**, you get coverage without needing to buy health insurance. This means you do not get help paying for health insurance through the new Health Insurance Marketplace. **[State CHIP program]** health coverage offers services at a much lower cost to you.
h.	Mixed Coverage Family: Children Eligible for CHIP; Ineligible for APTC/CSR	▪ **Ineligibility for APTC due to minimum essential coverage**	Because **<Person 1, Person 2, etc.>** qualify for **[State CHIP program]**, they get coverage without needing to buy health insurance. This means they do not get help paying for health insurance through the new Health Insurance Marketplace. **[State CHIP program]** health coverage offers services at a much lower cost to them.
4.	***CHIP Basis of Eligibility***		
a.	Individual/All Family Members: Basis for eligibility determination for CHIP (approval)	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and the information we got from other data sources. We found that your household size is **<applicant's household size> <person/people>** and your income is **$<applicant's monthly income>** each month. Since your monthly income is below the **[State CHIP program]** income **<limit/limits>**, **<Person 1, Person 2, etc.>** qualifies.
b.	Individual/All Family Members Basis for eligibility determination for CHIP (denial)	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and the information we got from other data sources. We found that your household size is **<applicant's household size>**

Notice Segment		Content Description	Key Message
			<person/people> and your income is $**<applicant's monthly income>** each month. The **[State CHIP program]** income limit for your household size is $**<income limit in dollar amount>** each month. Since your monthly income is above the **[State CHIP program]** income limit, **<Person 1, Person 2, etc>** does not qualify for **[State CHIP program]** health coverage. If you think we made a mistake, you can ask for a review. See the next page to learn more.
c.	Mixed Coverage Family: Basis for eligibility determination for CHIP (approval)	▪ **Basis of eligibility determination**	We counted your household size and income based on what you told us on your application and the information we got from other data sources. We found that your household size is **<applicant's household size> <person/people>** and your income is $**<applicant's monthly income>** each month. Since your monthly income is below the **[State CHIP program]** income limit, **<Person 1, Person 2, etc.>** qualify.
5.	***Determination for APTC/CSR***		
a.	Eligible for APTC		
b.	Eligible for CSR		
c.	Ineligible for APTC		
d.	Ineligible for CSR		
e.	Temporarily eligible APTC		
f.	Temporarily eligible for CSR		
g.	Reminder of potential APTC/CSR eligibility	▪ Consumer assessed APTC/CSR eligible; reminder of potential APTC/CSR eligibility and instructions for getting more information.	You can still get health coverage – and help paying for it – through the Health Insurance Marketplace. Be sure to read the letter they sent you. You can also call them at **[phone number]** (TTY: **[TTY phone number]**) or go to **[Marketplace website address]** for more information.
h.	APTC discontinuance (when individual assessed Medicaid ineligible by Marketplace and requests Medicaid review)	▪ Notice of discontinuation of APTC/CSR eligibility due to Medicaid eligibility determination	Because you qualify for **[State Medicaid program]**, you will no longer get a tax credit and lower co-payments through the Health Insurance Marketplace. They will send you more information. **[State Medicaid program]** health

Notice Segment		Content Description	Key Message
			coverage offers services at much lower cost to you.
6.	***Basis of Eligibility for APTC/CSR***		
a.	Basis for eligibility determination for APTC/CSR		
7.	***Determination for QHP***		
a.	Eligible for QHP		
b.	Ineligible for QHP		
c.	Temporarily eligible for QHP		
8.	***Basis of Eligibility for QHP***		
a.	Basis for Eligibility Determination for QHP		
9.	Did not act on application because enrolled in Medicaid/CHIP		
10.	***Assessment and Determination for Medicaid/CHIP***		
a.	Individual: Assessed Eligible for Medicaid; Determined Eligible for Medicaid	▪ **Decision on application**	They thought you qualified for **[State Medicaid program]**, and we decided that you do.
b.	All Family Members: Assessed Eligible for Medicaid; Determined Eligible for Medicaid	▪ **Decision on application**	They thought you, **<Person 2, etc.>** qualified for **[State Medicaid program]**, and we decided that you do.
c.	Mixed Coverage Family: Children Assessed Eligible for Medicaid; Determined Eligible for Medicaid	▪ **Decision on application**	They thought **<Person 1, Person 2, etc.>** qualified for **[State Medicaid program]**, and we decided that they do.
d.	Individual: Assessed Ineligible for Medicaid; Determined Eligible for Medicaid	▪ **Decision on application**	They did not think you qualified for **[State Medicaid program]** health coverage, but you asked for our review. We reviewed your application. We decided that you do qualify.
e.	All Family Members: Assessed Ineligible for	▪ **Decision on application**	They did not think you, **<Person 2, etc.>** qualified for **[State Medicaid program]** health coverage, but you asked

Notice Segment		Content Description	Key Message
	Medicaid; Determined Eligible for Medicaid		for our review. We reviewed your application. We decided that you, **<Person 2, etc.>** do qualify.
f.	Mixed Coverage Family: Children Assessed Ineligible for Medicaid; Determined Eligible for Medicaid	▪ **Decision on application**	They did not think **<Person 1, Person 2, etc.>** qualified for **[State Medicaid program]** health coverage, but you asked for our review. We reviewed your application. We decided that **<Person 1, Person 2, etc.>** do qualify.
g.	Individual: Assessed Eligible for Medicaid; Determined Ineligible for Medicaid	▪ **Decision on application**	They thought you qualified for **[State Medicaid program]** health coverage, but we decided that you do not qualify for **[State Medicaid program]** health coverage.
h.	All Family Members: Assessed Eligible for Medicaid; Determined Ineligible for Medicaid	▪ **Decision on application**	They thought you, **<Person 2, etc.>** qualified for **[State Medicaid program]** health coverage, but we decided that you, **<Person 2, etc.>** do not qualify for **[State Medicaid program]** health coverage.
i.	Mixed Coverage Family: Children Assessed Eligible for Medicaid; Determined Ineligible for Medicaid	▪ **Decision on application**	They thought **<Person 1, Person 2, etc>** qualified for **[State Medicaid program]** health coverage, but we decided that **<Person 1, Person 2, etc.> do not** qualify for **[State Medicaid program]** health coverage.
j.	Individual: Assessed Ineligible for Medicaid; Determined Ineligible for Medicaid	▪ **Decision on application**	They did not think you qualified for **[State Medicaid program]**, but you asked for our review. We reviewed your application. We decided that you do not qualify for **[State Medicaid program]** health coverage.
k.	All Family Members: Assessed Ineligible for Medicaid; Determined Ineligible for Medicaid	▪ **Decision on application**	They did not think you, **<Person 2, etc.>** qualified for **[State Medicaid program]**, but you asked for our review. We reviewed your application. We decided that you, **<Person 2, etc.>** do not qualify for **[State Medicaid program]** health coverage.
l.	Mixed Coverage Family: Children Assessed Ineligible for Medicaid; Determined Ineligible for Medicaid	▪ **Decision on application**	They did not think **<Person 1, Person 2, etc.>** qualified for **[State Medicaid program]**, but you asked for our review. We reviewed your application. We decided that **<Person 1, Person 2, etc.>** do not qualify for **[State Medicaid program]** health coverage.
11.	***Coverage Effective Date***		

Notice Segment		Content Description	Key Message
a.	Individual/ All Family Members: Medicaid	▪ **Coverage effective date (application date/first day of the month of application).**	Your coverage <starts/started> on <**Month, Day, Year**>.
b.	Mixed Coverage Family: CHIP	▪ **Coverage effective date (application date/first day of the month of application).**	Their health coverage <starts/started> on **<Month, Day, Year>**.
c.	Temporarily eligible for Medicaid	▪ **Coverage effective date (application date/first day of the month of application).**	Your health coverage <starts/started> on **<Month, Day, Year>** and you can use it right away.
d.	Individual: CHIP	▪ **Coverage effective date (application date/first day of the month of application) pending payment of first premium.**	**<Person 1>'s** health coverage will start on **<Month, Day, Year>**, as long as you:
e.	Mixed Coverage Family: CHIP	▪ **Coverage effective date (application date/first day of the month of application) pending payment of first premium.**	Their health coverage will start on **<Month, Day, Year>**, as long as you:
f.	APTC/CSR		
g.	QHP		
12.	***Transfers***		
a.	Received from Marketplace	▪ **Explanation that IAP application was transferred from the Marketplace**	We got your application from the Health Insurance Marketplace.
b.	Transfer to State Medicaid Agency for full Medicaid determination		
c.	Transfer to State CHIP Agency for full CHIP determination		
d.	Transfer to Marketplace for QHP/APTC/CSR determination	▪ **Transfer of application to Marketplace for APTC/CSR/QHP determination.**	But, you might still be able to get health coverage – and help paying for it – through the new Health Insurance Marketplace. We sent your application to them. The

Notice Segment		Content Description	Key Message
			Marketplace will send you a letter letting you know what to do next. If you do not hear from the Marketplace shortly, please call them at **[phone number]** (TTY: **[TTY phone number]**). In the meantime, you can create a Marketplace user account. To create an account, go to HealthCare.gov/marketplace and click "Account Setup." This user account is different from a **[State Medicaid program]** user account.
e.	Transfer to Marketplace for QHP/APTC/CSR determination (CHIP)	▪ **Transfer of application to Marketplace for APTC/CSR/QHP determination.**	But, he/she might still be able to get health coverage – and help paying for it – through the new Health Insurance Marketplace. We sent your application to them. The Marketplace will send you a letter letting you know what to do next. If you do not hear from the Marketplace shortly, please call them at **[phone number]** (TTY: **[TTY phone number]**). In the meantime, you can create a Marketplace user account. To create an account, go to HealthCare.gov/marketplace and click "Account Setup." This user account is different from a **[State CHIP program]** user account.
f.	Transfer to Marketplace for QHP/APTC/CSR determination (Emergency Medicaid)	▪ **Transfer of application to Marketplace for APTC/CSR/QHP determination.**	You also might be able to get more health coverage – and help paying for it – through the new Health Insurance Marketplace. We sent your application to them. The Marketplace will send you a letter letting you know what to do next. If you do not hear from the Marketplace shortly, please call them at **[phone number]** (TTY: **[TTY phone number]**). In the meantime, you can create a Marketplace user account. To create an account, go to HealthCare.gov/marketplace and click "Account Setup." This user account is different from a **[State Medicaid program]** user account.

Notice Segment		Content Description	Key Message
g.	Transfer to State Medicaid Agency from Marketplace; Applicant Eligible for APTC/CSR	▪ **Transfer of application to State Medicaid Agency; determined APTC/CSR eligible, assessed Medicaid ineligible and asked for review of Medicaid eligibility; SMA determined ineligible for Medicaid**	But, you still qualify for health coverage – and help paying for it – through the new Health Insurance Marketplace. Be sure to read the letter they sent you. You can also call them at **[phone number]** (TTY: **[TTY phone number]**) or go to HealthCare.gov/marketplace to learn more.
13.	***Non-MAGI and ABP Exemption***		
a.	Opportunity to be screened for non-MAGI (approval for Medicaid based on MAGI) / to be exempt from mandatory enrollment in ABP	▪ **Opportunity for non-MAGI Medicaid eligibility determination and explanation of non-MAGI Medicaid eligibility basis and benefits.** ▪ **Instructions for pursuing non-MAGI determination.** ▪ **Opportunity for exemption from mandatory enrollment in ABP (if applicable).**	A person may qualify to get more health services if he or she has special health care needs. A person who pays for care may also qualify to pay less. Special health care needs include if a person: o Has a medical, mental health or substance use condition that limits his or her ability to work or go to school o Needs help with daily activities, like bathing or dressing o Regularly gets medical care, personal care, or health services at home or in another community setting, like adult day care o Lives in a long term care facility, group home, or nursing home o Pays a lot for health care o Is blind o Is terminally ill If a person has any of these special health care needs, and wants to see if he or she qualifies, let us know. Call us at **[phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**. If the person has health coverage, he or she can keep it while we look at the information.
b.	Opportunity to be screened for non-MAGI (denial for Medicaid based on MAGI) /	▪ **Opportunity for non-MAGI Medicaid eligibility determination and explanation of non-MAGI**	A person may still be able to get **[State Medicaid program]** health coverage if he or she has special health care needs. **[State Medicaid program]** health coverage

Notice Segment		Content Description	Key Message
	to be exempt from mandatory enrollment in ABP	**Medicaid eligibility basis and benefits.** ▪ **Instructions for pursuing non-MAGI determination.** ▪ **Opportunity for exemption from mandatory enrollment in ABP (if applicable).**	offers more health services and lower costs. Special health care needs include if a person: o Has a medical, mental health, or substance use condition that limits his or her ability to work or go to school o Needs help with daily activities, like bathing or dressing. o Regularly gets medical care, personal care, or health services at home or in another community setting, like adult day care o Lives in a long term care facility, group home, or nursing home o Pays a lot for health care o Is blind o Is terminally ill If a person has any of these special health care needs, and wants to see if he or she qualifies, let us know. Call us at **[phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**. If the person has health coverage, he or she can keep it while we look at the information.
c.	Opportunity to be screened for non-MAGI (CHIP)	▪ **Opportunity for non-MAGI Medicaid eligibility determination and explanation of non-MAGI Medicaid eligibility basis and benefits. Instructions for pursuing non-MAGI determination.**	A person may still be able to get **[State Medicaid program]** health coverage if he or she has special health care needs, like: o Has a medical, mental health, or substance use condition that limits his or her ability to work or go to school o Needs help with daily activities, like bathing or dressing. o Regularly gets medical care, personal care, or health services at home or in another community setting, like adult day care o Lives in a long term care facility, group home, or

Notice Segment		Content Description	Key Message
			nursing home o Pays a lot for health care o Is blind o Is terminally ill If a person has any of these special health care needs, and wants to see if he or she qualifies, let us know. Call us at **[phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**. If the person has health coverage, he or she can keep it while we look at the information.
14.	***Opportunity to be exempt from mandatory enrollment in ABP due to 1931 eligibility***	▪ **Opportunity for exemption from mandatory enrollment in ABP due to eligibility as parent/caretaker under 1931 (if applicable)**	Adults with incomes under $**[State's monthly 1931 AFDC limit]** each month qualify for more health services. If you think we made a mistake counting your income, you can appeal. See the next page to learn how to appeal.
15.	***Notice to Employer***		
16.	***Date of Application***	▪ **Date of application**	Health coverage application date: **<Month, day, year>**
17.	Assistance with Past Medical Bills	▪ Financial assistance for three months retroactive coverage. ▪ Contact information for consumer to receive more information about retroactive coverage.	**[State Medicaid program]** may pay past bills, even if you already paid them yourself. Send your medical bills from the last three months to **[Medicaid billing office address]**.
C. Special Population for Medicaid/CHIP			
1.	Availability of EPSDT and need for immunizations (Medicaid)		
2.	Availability of special supplemental nutrition programs (Medicaid)		
3.	Use of Express Lane Eligibility, child may qualify for lower premiums (CHIP)		

Notice Segment		Content Description	Key Message
4.	Use of Express Lane Eligibility, child may qualify for Medicaid (CHIP)		
D. Rights and Responsibilities			
1.	***Cost Sharing Obligations/Assistance***		
a.	Individual: Medicaid premium information	▪ **Consumer premium obligations,** ▪ **Contact information for consumer to receive more information on premiums.**	*If there is no premium:* You do not have to pay a premium (a monthly cost) for your health coverage. *If there is a premium:* You have a premium (a monthly cost) of **$<premium amount>** for your health coverage.
b.	Individual: Medicaid co-pay information	▪ **Consumer co-payment obligations,** ▪ **Contact information for consumer to receive more information on co-payments.**	*If co-payments are not delivered with the eligibility determination notice:* ▪ You do have co-payments for some health services. There are different co-payments for different health services. But, there is a limit to your costs each month. How much you pay for co-payments and the limit to your monthly costs both depend on your income. If you think we made a mistake on your household size or income, and want to see if you qualify to pay less, you can appeal. See the last page to learn more. We will send you more information about your co-payments and monthly limit. Your health plan also will send you more information about health services and co-payments. To learn more now, go to medicaid.state.gov. *If co-payments are delivered with the eligibility determination notice:* You will have the following co-payments when you get health services: o **[Office visits]**: **[amount]**

Notice Segment		Content Description	Key Message
			o **[Hospital stays]**: **[amount]** o **[Prescriptions]**: **[amount]** How much you pay for co-payments and your monthly limit depend on your income. If you think we made a mistake on your household size or income, and want to see if you qualify to pay less, you can appeal. See the last page to learn more. More information about your co-payments and monthly limit is at **[website address]**.
c.	Temporary Medicaid Eligibility: Medicaid co-pay information	▪ **Consumer co-payment obligations,** ▪ **Contact information for consumer to receive more information on co-payments.**	*If co-payments are not delivered with the eligibility determination notice:* You do have co-payments for some health services. There are different co-payments for different health services. But, there is a limit to your costs each month. How much you pay for co-payments and the limit to your monthly costs both depend on your income. We will send you more information on health services, co-payments, and the monthly limit. To learn more now, go to **[website address]**. *If co-payments are delivered with the eligibility determination notice:* You have the following co-payments when you get health services: o **[Office visits]**: **[amount]** o **[Hospital stays]**: **[amount]** o **[Prescriptions]**: **[amount]** We will send you more information about your co-payments and monthly limit. Your health plan also will send you more information about health services and co-payments. To learn more now, go to **[website address].**

Notice Segment		Content Description	Key Message
d.	Mixed Coverage Family: Medicaid premium and co-payment information for members of the household who are eligible for Medicaid (no premiums or co-payments)	▪ **Consumer premium obligations.** ▪ **Consumer co-payment obligations.** ▪ **Contact information for consumer to receive more information on premiums and co-payments.**	You do not have to pay a premium (a monthly cost) for their health coverage or co-payments when they get health services.
e.	Individual: Medicaid cost-sharing payment and benefits instructions	▪ Consumer cost-sharing payment and benefits instructions.	Your health plan/We also will send you more information about health services and co-payments. To learn more now, go to **[website address]**.
f.	All Family Members: Medicaid cost-sharing payment and benefits instructions	▪ Consumer cost-sharing payment and benefits instructions.	Your health plan(s)/We also will send you more information about health services and co-payments. To learn more now, go to **[website address]**.
g.	Mixed Coverage Family: Medicaid cost-sharing payment and benefits instructions for members of the household (no premiums or co-payments)	▪ Consumer cost-sharing payment and benefits instructions.	Their health plan/We also will send you more information. To learn more now, go to **[website address]**.
h.	All Family Members: Medicaid premium and co-payment information	▪ **Consumer premium obligations.** ▪ **Consumer co-payment obligations.** ▪ **Contact information for consumer to receive more information on premiums and co-payments.**	You do not have to pay a premium (a monthly cost) for your **[State Medicaid program]** health coverage. Also, you do not have to pay co-payments for children's health services. You do have co-payments for some adult health services. There are different co-payments for different health services. But, there is a limit to your costs each month. How much you pay for co-payments and the limit to your monthly costs both depend on your income. If you think we made a mistake on your household size or income, and want to see if you qualify to pay less, you can appeal. See the last page to learn more.
i.	Individual: CHIP premium information	▪ **Consumer premium and enrollment fee obligations.**	The total premium (monthly cost) for health coverage for **<Person 1>** is $**<premium amount>**.

Notice Segment		Content Description	Key Message
		▪ **Contact information for consumer to receive more information on premium and enrollment fees.**	
j.	Multiple Children Eligible for CHIP: CHIP premium information	▪ **Consumer premium and enrollment fee obligations.** ▪ **Contact information for consumer to receive more information on premium and enrollment fees.**	The total premium (monthly cost) for health coverage for **<Person 1, Person 2, etc.>** is $**<premium amount>.**
k.	Mixed Coverage Family: CHIP premium information	▪ **Consumer premium and enrollment fee obligations.** ▪ **Contact information for consumer to receive more information on premium and enrollment fees.**	You also have to continue to pay a premium for their health coverage. But, there is a limit to your costs each month. You will not have to pay more than $**<5 % of income dollar amount>** (5% of your income) for their health care in the next 12 months. How much you pay for your premium and co-payments and the limit for your monthly costs all depend on your income. If you think we made a mistake on your household size or income, and want to see if you qualify to pay less, you can ask for a review. See the last page the learn more.
l.	Individual: CHIP co-pay information		
m.	Mixed Coverage Family: CHIP co-pay information	▪ **Consumer co-payment obligations.** ▪ **Contact information for consumer to receive more information on co-payments.**	You do have co-payments for some of their health services. There are different co-payments for different health services.
n.	Individual: CHIP premium payment instructions	▪ Consumer premium payment instructions.	We will send you a bill with payment instructions.
o.	Mixed Coverage Family: CHIP cost-sharing payment instructions	▪ Consumer cost-sharing payment instructions.	Their health plan will send you more information about health services and costs. To learn more now, go to **[CHIP website]**.
p.	Max APTC information		
q.	Max CSR information		
r.	Plan-specific QHP Premium and APTC information		

Notice Segment		Content Description	Key Message
s.	Plan-specific CSR information		
t.	Reconciliation at End of Year		
u.	Option to contribute more premium		
v.	Plan-specific QHP Premium information (no financial assistance)		
w.	QHP Premium Payment Instructions		
2.	***Plan Selection /Enrollment***		
a.	Individual: Instructions for enrollment in Medicaid MCO	▪ Instructions for plan selection ▪ *State-specific Messaging:* Notification that if plan is not selected within specified number of days, consumer will be auto-assigned. Consumer can access fee-for-service Medicaid in the interim.	We will also send you information about choosing a health plan, which you will need to do in the next **[number]** days. Once you join a plan, you will need to use the plan's health care providers. To learn more about your plan choices and providers now, call us at **[enrollment broker phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**.
b.	All Family Members: Instructions for enrollment in Medicaid MCO	▪ Instructions for plan selection ▪ *State-specific Messaging:* Notification that if plan is not selected within specified number of days, consumer will be auto-assigned. Consumer can access fee-for-service Medicaid in the interim.	We will also send you information about choosing health plans, which you will need to do in the next **[number]** days. Once you join a plan, you will need to use the plan's health care providers. To learn more about plan choices and providers now, call us at **[enrollment broker phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**.
c.	Mixed Coverage Family: Instructions for enrollment in Medicaid MCO	▪ Instructions for plan selection ▪ *State-specific Messaging:* Notification that if plan is not selected within specified number of days, consumer will be auto-assigned. Consumer can access fee-for-service Medicaid in the interim.	We will also send you information about choosing a health plan for them, which you will need to do in the next **[number]** days. Once they join a plan, they will need to use the plan's health care providers. To learn more about plan choices and providers now, call us at **[enrollment broker phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**.
d.	Enrolled in MCO plan		

Notice Segment		Content Description	Key Message
e.	Right to Change Plans		
f.	Individual: Instructions for enrollment in CHIP MCO	▪ Instructions for plan selection ▪ *State-specific Messaging:* Notification that if plan is not selected within specified number of days, consumer will be auto-assigned.	We will also send you information about choosing a health plan for **<Person 1>**. To learn more about plan choices now, call us at **[enrollment broker phone number]** (TTY: **[TTY phone number]**) or go to **[CHIP website address]**. Remember, their health coverage will not start unless you pay their premium and choose a health plan for them by the due dates.
g.	Mixed Coverage Family: Instructions for enrollment in CHIP MCO	▪ Instructions for plan selection ▪ *State-specific Messaging:* Notification that if plan is not selected within specified number of days, consumer will be auto-assigned.	We will send you information about choosing health plans for **<Person 1, Person 2, etc.>**. To learn more about plan choices now, call us at **[enrollment broker phone number]** (TTY: **[TTY phone number]**) or go to **[CHIP website address]**. Remember, **<Person 1, Person 2, etc.>**'s health coverage will not start until you pay their premium and choose a health plan for them. Watch for more letters with instructions and due dates.
h.	Enrolled in CHIP plan		
i.	Right to Change Plans		
j.	Instructions for enrollment in QHP		
k.	Enrolled in QHP		
l.	Open and Special Enrollment Periods		
3.	***Obligation to Report Changes***		
a.	Individual: Medicaid	▪ **Consumer change reporting responsibilities, including circumstances and timeframes in which changes must be reported (e.g., residency, income,**	You must report any changes that might affect your health coverage. Please report changes for both you and other people in your household, like: o If someone moves o If someone's income changes

Notice Segment		Content Description	Key Message
		household, immigration status). ▪ **Instructions for reporting changes.**	o If your household changes. For example, someone in your household marries or divorces, becomes pregnant, or has or adopts a child. To report changes, call us at **[phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**.
b.	Mixed Coverage Family: Medicaid	▪ **Consumer change reporting responsibilities, including circumstances and timeframes in which changes must be reported (e.g., residency, income, household, immigration status).** ▪ **Instructions for reporting changes.**	You must report any changes that might affect health coverage for **<Person 1, Person 2, etc.>**. Please report changes for both you and other people in your household, like if: o If someone moves o If someone's income changes o If your household changes. For example, someone in your household marries or divorces, becomes pregnant, or has or adopts a child. To report changes, call us at **[phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**.
c.	All Family Members: Medicaid	▪ **Consumer change reporting responsibilities, including circumstances and timeframes in which changes must be reported (e.g., residency, income, household, immigration status).** ▪ **Instructions for reporting changes.**	You must report any changes that might affect health coverage for you, **<Person 1, Person 2, etc.>**. Please report changes for both you and other people in your household, like : o If someone moves o If someone's income changes o If sour household changes. For example, someone in your household marries or divorces, becomes pregnant, or has or adopts a child. To report changes, call us at **[phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**.

Notice Segment		Content Description	Key Message
d.	CHIP	▪ Consumer change reporting responsibilities, including circumstances and timeframes in which changes must be reported (e.g., residency, income, household, immigration status). ▪ Instructions for reporting changes.	Report any changes that might affect health coverage for you, **<Person 1, Person 2, etc.>**. Please report changes for both you and other people in your household, like: o If someone moves o If someone's income changes o If sour household changes. For example, someone in your household marries or divorces, becomes pregnant, or has or adopts a child. To report changes, call us at **[phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**.
e.	APTC/CSR		
f.	QHP		
4.	***Termination of Coverage***		
5.	***Annual Renewal***		
a.	Individual: Medicaid/CHIP	▪ Notification of required renewal of Medicaid eligibility on annual basis. ▪ Expectation for additional information at renewal time.	You need to renew your health coverage every year. We will send you a letter when it is time to renew.
b.	Mixed Coverage Family: Medicaid/CHIP	▪ Notification of required renewal of Medicaid eligibility on annual basis. ▪ Expectation for additional information at renewal time.	You need to renew health coverage for **<Person 1, Person 2, etc.>** every year. We will send you a letter when it is time to renew.
c.	Mixed Coverage Family: Medicaid/CHIP	▪ Notification of required renewal of Medicaid eligibility on annual basis. ▪ Expectation for additional information at renewal time.	You need to renew health coverage for you, **<Person 1, Person 2, etc.>** every year. We will send you a letter when it is time to renew.
d.	APTC/CSR		
e.	QHP		
6.	***Benefits***		
a.	Individual: Medicaid	▪ **Services that benefit plan covers.**	You can get many health services through **[State Medicaid**

Notice Segment		Content Description	Key Message
		▪ **Population specific benefit language, e.g., EPSDT.** ▪ **Contact information for consumer to receive more information about benefit plan package.**	**program]**, like doctor's visits, hospital care, and prescriptions.
b.	All Family Members: Medicaid	▪ **Services that benefit plan covers.** ▪ **Population specific benefit language, e.g., EPSDT.** ▪ **Contact information for consumers to receive more information about benefit plan package.**	You, **<Person 1, Person 2, etc.>** can get many health services through **[State Medicaid program]**, like doctor's visits, hospital care, and prescriptions. (*If child in family*) Children can also get dentist visits and any health services that their doctors say they need.
c.	Mixed Coverage Family: Medicaid	▪ **Services that benefit plan covers.** ▪ **Population specific benefit language, e.g., EPSDT.** ▪ **Contact information for consumers to receive more information about benefit plan package.**	**<Person 1, Person 2, etc.>** can get many health services through **[State Medicaid program]**, like doctor's visits, hospital care, and prescriptions. (*If child in family*) They can also get dentist visits and any health services that their doctors say they need.
d.	Individual: Emergency Medicaid	▪ **Services that benefit plan covers.**	Your health coverage is only for emergencies, including labor and delivery if you are pregnant. It is not full **[State Medicaid program]** health coverage and does not cover preventative or non-emergency care.
e.	Individual: Medicaid Benefit Card	▪ Notification that consumer will receive Medicaid benefit card and may use it immediately to access benefits ▪ Instructions for card usage. ▪	You can get health services from any doctor, clinic, or other health care provider who accepts Medicaid. We will send you a Medicaid card. Until you get your card, you can get health services using your **[State Medicaid program]** ID Number: **<Benefit card number>**.

Notice Segment		Content Description	Key Message
f.	All Family Members: Medicaid Benefit Card	▪ Notification that consumers will receive Medicaid benefit card and may use it immediately to access benefits ▪ Instructions for card usage. ▪	You, **<Person 1, Person 2, etc.>** can start using your health coverage right away! You can get health services from any doctor, clinic, or other health care provider who accepts Medicaid. We will send you your Medicaid cards. Until you get your cards, you can use your Medicaid ID numbers to get health services. Your Medicaid ID numbers are: **<Person 1>**: **<Benefit card number>** **<Person 2>**: **<Benefit card number>**
g.	Mixed Coverage Family: Medicaid Benefit Card	▪ Notification that consumers will receive Medicaid benefit card and may use it immediately to access benefits ▪ Instructions for card usage. ▪	**<Person 1, Person 2, etc.>** can start using their health coverage right away! They can get health services through any doctor, clinic, or other health care provider who accepts Medicaid. We will send you their Medicaid cards. Until you get their cards, they can use their Medicaid ID numbers to get health services. Their Medicaid ID numbers are: **<Person 1>**: **<Benefit card number>** **<Person 2>**: **<Benefit card number>**
h.	Individual: Emergency Medicaid Benefit Card	▪ Notification that consumers will receive Medicaid benefit card and may use it immediately to access benefits ▪ Instructions for card usage. ▪	We will send you a **[State Medicaid program]** card. Until you get your card, you can use your Medicaid ID number: **<Medicaid ID number>**. To learn more, go to **[Medicaid website]**.
i.	Individual: CHIP	▪ **Services that benefit plan covers.** ▪ **Contact information for consumer to receive more information about benefit plan package.**	**<Person 1>** can get many health services through **[State CHIP program]**, like doctor's visits, dentist visits, hospital care, prescriptions, and much more.
j.	Mixed Coverage Family: CHIP	▪ **Services that benefit plan covers.** ▪ **Contact information for consumer to receive more information about**	**<Person 1, Person 2, etc.>** can get many health services through **[State CHIP program]**, like doctor's visits, dentist visits, hospital care, prescriptions, and much more.

Notice Segment		Content Description	Key Message
		benefit plan package.	
k.	QHP		
E. Appeals			
1.	***Medicaid***		
a.	Right to appeal/fair hearing	▪ **Consumer right to appeal and reasons consumer may want to pursue an appeal.**	You can appeal our decisions about **[State Medicaid program]** health coverage. For example, you can appeal if you think we made a mistake on your household size, income, citizenship, immigration status, or residency. You can also appeal what health services you get and how much you pay for them.
b.	Instructions for how to appeal	▪ **Instructions to appeal, access additional information about appeals** ▪ **Appeal deadline**	To ask for an appeal, call us at **[phone number]** (TTY: **[TTY phone number]**). Or, go to **[website address]** to get an appeals form. Or, you can write your own letter and send or bring it to us at **[State Medicaid program], [Medicaid Agency address]**. You must ask for an appeal by **<Month, Day, Year>**. Once you ask for an appeal, we will try to see if we can fix the problem over the phone or by meeting with you. If a phone call or meeting does not fix the problem, you can have a hearing. A hearing is a meeting between you, someone from the State Medicaid Agency, and a hearing officer. At the hearing, you can explain why you think we made a mistake. To get ready for your hearing, you can: • Ask for a copy of your file before the hearing. • Bring someone with you to the hearing, like a friend, relative, or lawyer, or, come by yourself. • Bring documents, information, or witnesses to show us where you think we made a mistake.

Notice Segment		Content Description	Key Message
			If a person has health coverage, he or she can keep it during an appeal. If you have questions, call us at **[phone number]** (TTY: **[TTY phone number]**).
2.	***CHIP***		
a.	Right to review	▪ **Consumer right to review**	You can ask for a review of our decisions about health coverage. You have **<number of days>** to ask for a review of our decisions.
b.	Instructions for how to ask for a review - CHIP	▪ **Instructions to ask for review and access additional information about reviews.**	To ask for a review: • Call us at **[phone number]** (TTY: **[TTY phone number]**). • Go to **[CHIP website]**. • Send us a fax at **[fax number]**. • Email us at **[email address]**. If you ask for a review of whether a person qualifies for **[State Medicaid program]**, we will send your application to the [**State Medicaid Agency]**. They will send you a letter to let you know if the person qualifies.
3.	***APTC/CSR***		
a.	Right to appeal/fair hearing		
b.	Instructions for how to appeal		
4.	***QHP***		
a.	Right to appeal/fair hearing		
b.	Instructions for how to appeal		
F. Other			
1.	Logo/Letterhead	▪ Agency logo	**[Agency logo]**
2.	Applicant Name and Address	▪ Applicant contact information	**<Applicant First and Last Name>**

Notice Segment		Content Description	Key Message
			<Applicant Mailing Address>
3.	Date of Notice	▪ **Date of notice**	Letter date: **<Month, Day, Year>**
4.	Letter ID Number	▪ Unique notice identifier	Letter number: **<Letter unique identifier>**
5.	Account Information/User ID	▪ Information about secure user account	**[Website address]** keeps all important information about your application and health coverage. You can choose to get letters like this online. To create an account, go to **[website address]** and click "Account Setup".
6.	Incomplete Application Reminder (Variable: Timeframe)		
7.	Application currently being evaluated		
8.	Accessibility	▪ **Statement indicating availability of language services.** ▪ **Availability of ADA/504 compliant aids and language services.**	You can get this letter in another language, in large print, or in another way that's best for you. Call us at **[phone number]** (TTY: **[TTY phone number]**).
9.	Accessibility in Spanish	▪ **Same as above, but written in Spanish**	Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos al **[phone number]** Las personas con problemas para oir - TTY: **[TTY phone number]**).
10.	Legal Authority (single citation)	▪ **Citation to or identification of specific regulation supporting action.**	We made our decision based on this rule: **<citation for regulation supporting action>**
11.	Legal Authority (multiple citations)	▪ **Citation to or identification of specific regulations supporting action.**	We made our decisions based on these rules: **<citation for regulations supporting action>**
12.	Individual: Other Benefit Programs – Medicaid	▪ Possible eligibility for other public benefits. ▪ Contact information for consumer to receive additional information about eligibility for other public benefits.	Because you qualify for **[State Medicaid program]**, you may also qualify for other assistance, like help buying food. To learn more, call **[phone number]** (TTY: **[TTY phone number]**).

Notice Segment		Content Description	Key Message
13.	Mixed Family: Other Benefit Programs – Medicaid	▪ Possible eligibility for other public benefits. ▪ Contact information for consumer to receive additional information about eligibility for other public benefits.	Because **<Person 1, Person 2, etc.>** qualify for **[State Medicaid program]**, you may also qualify for other assistance, like help buying food. To learn more, call **[phone number]** (TTY: **[TTY phone number]**).
14.	All Family Members: Other Benefit Programs – Medicaid	▪ Possible eligibility for other public benefits. ▪ Contact information for consumer to receive additional information about eligibility for other public benefits.	Because you, **<Person 1, Person 2, etc.>** qualify for **[State Medicaid program]**, you may also qualify for other assistance, like help buying food. To learn more, call **[phone number]** (TTY: **[TTY phone number]**).
15.	Mixed Family: Other Benefit Programs – CHIP	▪ Possible eligibility for other public benefits. ▪ Contact information for consumer to receive additional information about eligibility for other public benefits.	Because <**Person 1, Person 2, etc.**> qualify for **[State CHIP program]**, you may also qualify for other assistance, like help buying food. To learn more, call **[phone number]** (TTY: **[TTY phone number]**).
16.	Consumer Assistance	▪ **Consumer assistance contact information.**	**[Icon/Graphic]** Questions? Call us at **[phone number]** (TTY: **[TTY phone number]**) or go to **[website address]**. You can call **[days and hours of operations]**. The call is free. Or, go to **[website address]**. You can also find out how to meet with someone in person.
17.	***American Indian/Alaskan Native Rights***		
a.	Medicaid		
b.	CHIP		
c.	QHP		
18.	Summary of Coverage (Mixed Coverage Family Notices)	▪ Record of application date and persons for whom individual applied.	Our records show that you applied for health coverage for you **<Person 1, Person 2, etc.>** on **<application date>**.
19.	Summary of Coverage (Mixed Coverage Family Notices): Persons Eligible for Medicaid	▪ Decision on application. ▪ Notification that eligibility information and cost sharing	They qualify for **[State Medicaid program]** health coverage. Please read the rest of this letter to learn more.

Notice Segment		Content Description	Key Message
		obligations are enclosed.	
20.	Summary of Coverage (Mixed Coverage Family Notices): Persons determined Ineligible for Medicaid and Potentially Eligible for Tax Credits	▪ Notification that consumer appears eligible for APTC/CSR and will be hearing from the Marketplace. ▪ Additional information is enclosed.	We are still working to see what health coverage you qualify for. You might be able to get health coverage – and help paying for it – through the new Health Insurance Marketplace. We sent your application to them. The Marketplace will send you a letter letting you know what to do next. If you do not hear from the Marketplace shortly, please call them at **[phone number]** (TTY: **[TTY phone number]**). In the meantime, you can create a Marketplace user account. To create an account, go to HealthCare.gov/marketplace and click "Account Setup." This user account is different from a **[State Medicaid program]** user account.
21.	Summary of Coverage (Mixed Coverage Family Notices): Persons Determined Ineligible for Medicaid and Determined Eligible for Tax Credits	▪ Notification that consumer was determined eligible for APTC/CSR and will hear from the Marketplace soon	You still qualify for health coverage – and help paying for it – through the new Health Insurance Marketplace. Be sure to read the letter they sent you. You can also call them at **[phone number]** (TTY: **[TTY phone number]**) or go to HealthCare.gov/marketplace to learn more.
22.	Summary of Coverage (Mixed Coverage Family Notices): Received Application from Marketplace	▪ Application was received from Marketplace	You applied for health coverage for you, **<Person 1, Person 2, etc.>** on **<application date>** through the Health Insurance Marketplace. We got your application from the Marketplace.
23.	Summary of Coverage (Mixed Coverage Family Notices): Persons Assessed Eligible for Medicaid, Determined Eligible for Medicaid	▪ Application was received from Marketplace where consumer(s) assessed eligible for Medicaid.	They qualify for **[State Medicaid program].** The Health Insurance Marketplace thought they qualified, and we decided that they do. Please read the rest of this letter to learn more.
24.	Summary of Coverage (Mixed Coverage Family Notices): Persons Eligible for CHIP	▪ Decision on application ▪ Notification that eligibility information and cost sharing obligations are enclosed.	They qualify for **[State CHIP program]** health coverage. Please read the rest of this letter to learn more.

Notice Segment		Content Description	Key Message
25.	Disclosure/Privacy Statement	▪ Privacy/disclosure statement	We will keep your information secure and private.
26.	Signature	▪ Signature line	Sincerely,
27.	Issuing Agency and Contact	▪ Agency contact information	**[Agency Name]** **[Agency Address]**
G. Headers			
1.	Reason for Notice		Why you are getting this letter
2.	***Individual: Eligibility Determination***		
a.	Temporary Eligibility Summary		News for you
b.	Temporary Eligibility for Medicaid	▪ **Coverage during reasonable opportunity period**	For now, you have **[State Medicaid program]** health coverage
c.	Denial/Limited Coverage		Update for you
3.	***Mixed Coverage Family: Eligibility Determination***		
a.	Denial (Mixed Coverage Family)		Update for **<Person 1, Person 2, etc.>**
4.	***All Family Members: Eligibility Determination***		
a.	Approval (Mixed Coverage		Good news for you, **<Person 1, Person 2, etc.>**
5.	Additional Documentation Information: Income	▪ **Notification that consumer has set number of days to submit documentation in order to be considered for Medicaid eligibility.**	Please give us proof of your income by **<Month, Day, Year>**
6.	Additional Documentation Information: Citizenship	▪ Notification that eligibility determination cannot be made and temporary coverage will be terminated if documentation is not submitted by coverage end date.	But, you need to give us more information to keep your coverage
7.	How to Send Documentation		Four ways you can give us a copy of your document
8.	Reminder of Temporary Eligibility for Medicaid		Remember, your health coverage will end on **<Month, Day, Year>** if you do not give us proof of your citizenship.
9.	Summary Sheet: Application Date Record		News for you and your family
10.	Summary Sheet: Eligibility		Good news for **<Person 1, Person 2, etc.>**

Notice Segment		Content Description	Key Message
	Determination (Approval)		
11.	Summary Sheet: Eligibility Determination (Denial)		Update for **<Person 1, Person 2, etc.>**
12.	Individual: Benefit Card and Plan Selection Information and Instructions (Medicaid)		Using your health coverage
13.	Mixed Coverage Family: Benefit Card and Plan Selection Information and Instructions (Medicaid)		Using their health coverage
14.	Services and Cost Sharing Information and Instructions (Medicaid/CHIP)		Health services and costs
15.	Premium Payment (CHIP)		1. Pay their premium
16.	Plan Enrollment Instructions (CHIP)		2. Choose a health plan for them
17.	***Change Reporting***		
a.	Change Reporting (Medicaid)		You must report changes
b.	Change Reporting (CHIP)		Please report changes
18.	Account information		Your Secure User Account
19.	Renewal		Renewing your health coverage
20.	Renewal (Mixed Coverage Family)		Renewing their health coverage
21.	Basis for Eligibility Determination and Other Programs (Approval)		How we made our decisions and information about other programs
22.	Basis for Eligibility Determination and Other Programs (Denial/Limited Coverage)		How we made our decision
23.	***Basis for Eligibility Determination***		
a.	Basis for Eligibility for		How you qualify for Medicaid

Notice Segment		Content Description	Key Message
	Medicaid		
b.	Basis for Eligibility for Medicaid (Mixed Coverage Family)		How **<Person 1, Person 2, etc.>** qualify for Medicaid
c.	Basis for Eligibility for Medicaid (All Family Members)		How you, **<Person 1, Person 2, etc.>** qualify for Medicaid
d.	Basis for Eligibility for Medicaid (temporarily eligible)		How you qualify for Medicaid for now
e.	Basis for Eligibility for CHIP		How you qualify for CHIP
f.	Basis for Eligibility for CHIP (Mixed Coverage Family)		How **<Person 1, Person 2, etc.>** qualify for CHIP
g.	Basis for Ineligible for Medicaid		We do not think you qualify for Medicaid
h.	Basis for Ineligible for Medicaid (CHIP ineligible child)		We do not think **<Person 1>** qualifies for Medicaid
i.	Basis for Ineligible for Medicaid (Mixed Coverage Family)		We do not think **<Person 1, Person 2, etc.>** qualify for Medicaid
24.	Opportunity for More Health Services		You might qualify for more health services:
25.	Alternative Benefit Plan (ABP) AFDC Exemption		If your income is under $ **[State's parent/caretaker AFDC level]** each month
26.	Non-MAGI/ABP Exemptions		If you have special health care needs
27.	Non-MAGI/ABP Exemptions (Mixed Coverage Family)		If **<Person 1, Person 2, etc.>** has special health care needs
28.	Non-MAGI/ABP Exemptions (All Family Members)		If you, **<Person 1, Person 2, etc.>** has special health care needs
29.	Past Medical Bills		If you have medical bills from the last three months
30.	Past Medical Bills (Mixed		If **<Person 1, Person 2, etc.>** have medical bills from the

Notice Segment		Content Description	Key Message
	Coverage Family)		last three months
31.	Past Medical Bills (All Family Members)		If you, **<Person 1, Person 2, etc.>** have medical bills from the last three months
32.	Appeals		If you think we made a mistake