471-000-68 Instructions for Completing Form IM-8, "Notice of Finding"

Use: Form IM-8 is used to provide notice to the applicant for, or recipient of, Assistance to the Aged, Blind, or Disabled (AABD)/Medical Assistance (MA); State Disability Program (SDP)/MA; Aid to Dependent Children (ADC)/MA; Child Welfare Payment and Medical Services Program (CWP); Refugee Resettlement Program (RRP)/MA; Ribicoff; Medical Assistance for Children (MAC); Emergency Assistance (EA); or Nebraska Low Income Energy Assistance Program (LIEAP). The form notifies the person that (more than one may apply) -

1. The application for assistance is pending (A);
2. The application for assistance has been approved, rejected (B,I);
3. The client is eligible for a payment (C,D,I,J);
4. The client is eligible for assistance but will not receive a payment because the client's Supplemental Security Income (SSI) exceeds the budgetary needs. This is often referred to as "SSI override." The client is still considered grant status (E);
5. The client is eligible for MA (F);
6. The client is eligible for MA after an obligation is met (G,H);
7. The request for allowance of a special requirement has been approved, rejected (J);
8. The assistance payment and MA are suspended (K); or
9. The assistance payment and/or MA will be terminated (L,M).

Additionally, Form IM-8 is used to inform the client of -

1. The type(s), amount(s), and effective date(s) of assistance to be received (B,C,D,E,F,G,H,I,J);
2. The amount, duration, and the effective date(s) of the obligation (G,H);
3. The effective date(s) the assistance will be suspended or terminated (K,L,M);
4. The explanation of the worker's action(s), the reason(s) for the action(s), and the manual reference(s) that supports or the change(s) in federal or state law that requires the action(s) (Section VII);
5. The client's responsibility to provide complete and accurate information, to keep the local office informed of any change in circumstances, and to report these changes within a specified time period;
6. The discriminatory practices prohibited by the Civil Rights Act of 1964;
7. The client's right to a conference;
8. The client's right to a notice of any action(s) affecting the assistance case; or
9. The client's right to appeal and request a fair hearing, the conditions under which a hearing is granted, the time limit for filing a request for an appeal, the circumstances in which assistance will be continued, and the possibility of an overpayment resulting from assistance continued pending an appeal.

In all cases, the worker shall send adequate notice to the client of any action affecting his/her assistance case. In cases of intended adverse action (action to discontinue, terminate, suspend or reduce assistance, or to change the manner or form of payment or service to a more restrictive method, i.e., protective payee, medical lock-in), the worker shall give the client adequate and timely notice.

If a client agrees to waive his/her right to a timely notice in situations requiring timely notice, the

worker shall obtain a statement signed by the client to be filed in the case record.

Number Prepared: Form IM-8 is prepared in duplicate. In the situation where the client has an obligation to pay a nursing home or other medical facility (H), a copy of Form IM-8 is sent to the attention of the facility administrator.

Completion:

Field 1 - Case Number: Enter the case number (Social Security number) for the case.

Field 2 - Date: Enter the date the form is sent to the client.

Field 3 - Case Name: Enter the case name.

Field 4 - Local Office Name: Enter the name of the local office from which Form IM-8 is being sent.

Field 5 - Address: Enter the client's address.

Field 6 - Local Office Address: Enter the address of the local office.

Field 7 - IM Worker: Enter the name of the local worker who handles the case.

Check all the boxes, A through L, that apply to the action being taken. Section VII is used to explain the reason(s) for the action(s) taken.

Section I: Initial Eligibility.

Section I is used to indicate the eligibility status on an initial application for AABD/MA, ADC/MA, CWP, RRP/MA, Ribicoff, or MAC. For EA and Nebraska LIEAP, see Section IV.

Box A: Check Box A to notify the applicant that a determination regarding his/her application is pending. If the application cannot be acted on within 30 days from the date of request, Section VII may be used to indicate the reason for the delay and to indicate what items of information are needed in order to complete the determination of eligibility. Indicate the program for which the applicant has applied in field 8.

Box B: Check Box B to indicate the eligibility status on an initial application. Cross out either eligible or not eligible as appropriate. Indicate the program for which the applicant has applied in field 9.

Section II: Payment

Section II is used to indicate the payment status for clients eligible for AABD/MA, SDP/MA, ADC/MA, CWP, and RRP/MA. For EA and Nebraska LIEAP, see Section IV.

Box C: Check Box C to notify the client from which program s/he will be receiving a payment (field 10), the amount of the payment to be received (field 11), and the effective date (month, day, year) of the first payment (field 12). Box C is also used to notify the client of an increase or decrease in the assistance payment and the date the change is effective.

Note: Box C is used to indicate eligibility for payment amounts not affected by an SSI benefit. The payment the client receives will equal the budgetary need/payment amount on Form IM-25 or Form IM-25A. See box D for payment amounts affected by an SSI benefit.

Box D is used for AABD cases that are also receiving an SSI benefit.

Section III: Medical Assistance (Medicaid)

Use Section III to indicate the client's eligibility for AABD/MA, SDP/MA, ADC/MA, CWP, RRP/MA, Ribicoff, or MAC; and to inform the client whether s/he is eligible for MA with or without excess income.

Box E: Check Box E to notify the client of the effective date of his/her eligibility for MA. Enter the month, day, and year the eligibility for MA begins in field 15. When appropriate, Section VII may be used to indicate retroactive months of medical eligibility on an initial application.

Box F: Check Box F to notify the client that s/he is eligible for MA with share of cost/excess income. Enter the total amount of monthly share of cost/excess income that must be obligated in field 16. Indicate the month of the share of cost/excess income in field 17. Box F is also used to notify the client of changes in the monthly share of cost/excess income amounts. When appropriate, Section VII may be used to indicate share of cost/excess income for each retroactive active month of eligibility.

Box G: Check Box G to notify the client s/he is eligible for MA but that s/he has a monthly obligation to pay to the nursing facility, or other medical facility, or to a personal care aide. Enter the amount of monthly obligation in field 20. Enter the effective date (month, day, year) of the obligation in field 21. Additional space is allowed to indicate to whom the obligation is to be paid. When appropriate, Section VII may be used to identify several adjustments in obligations and/or facilities.

Section IV: Emergency Assistance/Nebraska Low Income Energy Assistance

Use Section IV to indicate the client's eligibility for assistance under the EA and Nebraska LIEAP Programs.

Box H: Complete Box H to indicate whether the client's application for EA or Nebraska LIEAP (cross out as appropriate) has been approved or rejected (cross out as appropriate). Additional space is allowed to describe the assistance to be received. Use Section VII to explain the action(s) taken.

Section V: Special Allowances

Use Section V to notify the client that a request for a home repair has been approved or rejected.

Box I: Check Box I to indicate what item was requested (field 22) and whether the request was approved or rejected (cross out as appropriate). Indicate the amount being allowed in field 23. Give an explanation of the special allowance in field 24, e.g., the effective date, the time period, the fact that it is a one-time only allowance.

Section VI: Suspension/Termination

Use Section VI to notify the client that payment and MA will be suspended or terminated.

Box J: Check Box J to notify the client that his/her payment and MA are being suspended. Indicate in field 25 the type of payment the client is receiving. Enter the month, day, and year the suspension becomes effective in field 26 and the last month (month, last day of the month, and year) of the suspension in field 27; for example, January 1, 1991 - March 31, 1991.

Box K: Check Box K to indicate those situations where the client is no longer eligible to receive a payment but will continue to receive MA. Indicate the effective date (month, day, year) of the change in field 28. Mark the appropriate box to indicate whether the client will continue to receive MA only or MA with excess income. If the client is eligible for MA only, additional space is allowed to indicate an automatic termination date, when appropriate. If the client is eligible for MA with excess income, complete Section III-Box F or G as appropriate.

Box L: Check Box L to notify the client that his/her assistance is being terminated. Enter the month, day, and year the termination is effective in field 29.

Section VII: Explanation

Section VII is used to explain the action(s) taken by the local office. The worker shall indicate in the space provided the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the federal or state law that requires the action(s).

Rights and Responsibilities: The reverse side of Form IM-8 includes statements regarding the client's rights and responsibilities.

Disposition: The original form is sent to the client. The duplicate is filed in the case record.

Filing Instructions: Form IM-8 is filed in section 2 of the case record.

Retention: Form IM-8 must be retained in the case file for four years.

Nebraska Department of Health and Human Services
NOTICE OF FINDING

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

This is your notice of the action(s) taken by the local office. All the boxes below that are checked apply to your situation. See Section VII for an explanation of the action(s) taken.

1. Master Case Number	2. Date
3. Case Name ▶ 5. Address ▶ ▶ ▶	4. Local Office Name 6. Local Office Address 7. IM Worker

SECTION I: INITIAL ELIGIBILITY

A. ❑ Your application for (8)_____ is being considered but a decision regarding your eligibility has not been made. Your case is pending until a determination can be made.

B. ❑ It has been determined that you are (eligible, not eligible) for (9)_____.

SECTION II: PAYMENT

C. ❑ Your monthly payment for (10)_____ will be (11)_____ beginning (12)_____.

D. ❑ Your AABD need standard is $_____ beginning_____. Your need standard will be paid from AABD, SSI, and any other income you may receive. If your SSI and other income are more than your need standard you will not receive an AABD payment. You will not receive your total need standard if your SSI is reduced because of an overpayment.

SECTION III: MEDICAL ASSISTANCE (MEDICAID)

E. ❑ You are eligible for medical assistance beginning (15)_____.

F. ❑ Your income exceeds medical assistance standards. Before the State can make medical payments on your behalf, you must obligate your share of cost (16) $_____ on current medical bills during the (17)_____ month period from (18)_____ to (19)_____. Once you have obligated the above amount, you must contact your IM worker before you can be authorized to receive medical services.

G. ❑ You are eligible for medical assistance. Since you are in a nursing home, medical facility or because you have a personal care aid, you must obligate (20) $_____ each month for your care. Your monthly obligation begins (21)_____.

SECTION IV: EMERGENCY ASSISTANCE / NEBRASKA LOW INCOME ENERGY ASSISTANCE

H ❑ Your application for assistance under the (Emergency Assistance, Energy Assistance) Program has been approved, rejected)._____.

SECTION V: SPECIAL ALLOWANCES

I. ❑ Your request for (22)_____ has been (approved, rejected). The allowance of (23) $_____ for this item will be (24)_____.

SECTION VI: SUSPENSION / TERMINATION

J. ❑ You will not receive your (25)_____ payment and medical assistance from (26)_____ to (27)_____.

K. ❑ You are no longer eligible to receive a payment effective (28)_____
- ❑ You will continue to receive medical assistance._____
- ❑ Your income exceeds medical assistance standards. See Section III.

L. ❑ You are no longer eligible. Your payment and medical assistance will be terminated effective (29)_____

SECTION VII: EXPLANATION

The reason(s) for the above action(s), and the manual reference(s) that supports or the change in federal or state laws that requires the action(s) are:_____

PLEASE READ THE BACK OF THIS NOTICE FOR YOUR RIGHTS.

PRINTED WITH SOY INK

YOUR RIGHTS

CIVIL RIGHTS

No person may be subjected to discrimination in any Department of Health and Human Services program or activity based on his/ her race, color, sex, age, national origin, religious creed, political beliefs or handicap. Any person who believes s/he has been subjected to discrimination may file a complaint with the Nebraska Department of Health and Human Services or with the U.S. Department of Health and Human Services.

RIGHT TO A CONFERENCE

You have the right to request a conference with your worker to discuss the reason(s) for the action(s) indicated on this form. To request a conference, you can call, write, or visit the local office. If you have questions about your application, payment or medical assistance, your worker will be glad to discuss your case with you.

RIGHT TO NOTICE OF ACTION

Adequate notice must be sent notifying you of any action(s) affecting your assistance case. Adequate means the notice must include a statement of what action(s) the local office intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s).

In cases of intended adverse action (action to discontinue, terminate, suspend or reduce your assistance, or to change the manner or form of your payment or service to a more restrictive method) you must receive adequate and timely notice. Timely mans that the notice is mailed at least ten calendar days before the date the action would become effective, which Is always the first day of the month. In certain situations, your worker may dispense with timely notice but shall send you adequate notice no later than the effective day of action. Your worker can explain these situations to you.

In cases where the local office obtains facts indicating that your assistance should be discontinued, suspended, terminated, or reduced because of probable fraud, and where possible, such facts have been verified through collateral sources, notice of such grant adjustment is considered timely if it is mailed at least five days before the action would become effective.

RIGHT TO APPEAL

You have the right to appeal for a hearing or inaction of any state employee or official with regard to application for or receipt of financial or medical assistance. You may appeal because your application for financial or medical assistance is denied or is not acted upon with a reasonable promptness; your assistance is suspended, reduced, discontinued or terminated; your form of payment or services is changed to a more restrictive method or because you feel the action taken by the local office with erroneous. A hearing need not be granted when either state or feral law requires automatic case adjustments for classes of clients unless the reason for an Individual appeal is incorrect eligibility determination.

If you request assistance from the local office under the Emergency Assistance Program, and the local office did not help you with your request, you may appeal the local office's actions or inactions to the Nebraska Department of Health and Human Services and' that office will provide you with a quick hearing and decision on your appeal. You may ask your worker for more information regarding the expedited appeal. 468 NAG 6-012.01.

You (or your representative) have 90 days following the date the notice of **finding is mailed to request a fair hearing.**

In cases of intended adverse action where the worker Is required to send you timely and adequate notice, if you **request an appeal hearing within ten days** following the **date the notice of finding Is mailed, your worker shall not carry out the adverse action until a fair hearing decision Is rendered. This regulation does not apply to those situations where the worker may dispense with** timely notice and Is only required to **send you adequate notice.**

This regulation in no way restricts your worker from continuing normal case activities and implementing changes to your assistance case that are not directly related to the appeal issue.

If, as a result of the hearing, the action taken by the local office Is **found to be correct, the disputed amount of assistance provided to you during the appeal period may be treated as an overpayment and recovery procedures may be Initiated by the local office.**

To file an appeal, you may contact the local division of social services or the Nebraska Department of Health and Human Services. Your worker will explain the appeal procedure and assist you in completing the appeal form. The appeal request must be in writing.

Once you've filed the appeal, arrangements for a hearing will be made and you will be notified of the time and place. You may represent yourself at the hearing or be represented by another person.