

Ohio Department of Medicaid
**NOTICE OF DENIAL OF YOUR REQUEST TO
TERMINATE MEMBERSHIP IN YOUR MANAGED CARE ORGANIZATION FOR “JUST CAUSE”
FROM THE OFFICE OF MANAGED CARE**
En Español 1-800-324-8680

Name			Parent/Authorized Representative	
Street Address			Case Number	Medicaid Billing Number
City	State	Zip Code	County	Mailing Date

The Ohio Department of Medicaid (ODM) has denied your request to terminate your membership with your managed care organization (MCO) _____ because you do not have “just cause.” You made your request on _____.

Based on the information available to us, you **do not** have “just cause” to terminate membership in the MCO because ODM has determined:

- You have not moved out of the MCO’s service area.
- The MCO is not denying you a medical service because the MCO has a moral or religious objection to providing the service.
- No medical provider, including your primary care provider (PCP), has determined that you need multiple medical services that should be provided at the same time to avoid unnecessary risk to you, but these services are not available through the MCO.
- You are not experiencing any of the following:
 - Poor quality of care, or
 - Lack of access to services, or
 - Lack of access to providers experienced in dealing with your health care needs
- There are other primary care providers (PCPs) in your MCO's network that speak your primary language or no other MCOs in your service area have a PCP who speaks your primary language.
- You are not in a situation that would be harmful to your interests if you remain a member of the MCO.

We based this decision on Ohio Administrative Code rule 5160-26-02.1.

If you do not understand this decision, or want to talk to us about it, you may call us:

Name	Toll-free telephone number
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If you disagree with our decision, or think we are making a mistake, you may appeal by asking for a State Hearing. Follow the instructions on the following pages to ask for a State Hearing.

ASK FOR A STATE HEARING IF YOU WANT TO APPEAL

Ask for a State Hearing if you disagree with our decision or think we are making a mistake. At the State Hearing you can explain your reasons. We will explain our reasons. A State Hearing Officer from the Ohio Department of Job and Family Services (ODJFS) will decide who is right.

We must receive your hearing request by this deadline: _____

Please use the next page ("*State Hearing Request*") to ask for a State Hearing. Save all other pages of this notice for your records.

Someone else may help you (*a lawyer, social worker, friend, relative, etc.*). Someone else may ask for the hearing for you and come to the hearing with you.

You can ask your local *Legal Aid* program for free help with your case. Call the *Ohio State Legal Services Association* at 1-800-589-5888 (*a free call*) if you need the local phone number.

To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to: oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling the Medicaid Consumer Hotline 1-800-324-8680; individuals with a hearing impairment may call TDD 7-1-1.

Spanish

Para ayudarle a comprender este aviso, se encuentran disponibles a pedido asistencia lingüística, servicios de interpretación, ayudas auxiliares y otros servicios sin costo alguno. Los servicios disponibles incluyen, entre otros: traducción oral, traducción escrita y ayudas auxiliares. Puede solicitar estos servicios o ayudas auxiliares llamando a la Línea directa para el consumidor del Departamento de Medicaid de Ohio al 1-800-324-8680; las personas con discapacidad auditiva pueden llamar al TDD 7-1-1.

Nepali

यो सूचना बुझ्न सहायता गर्न, भाषा सहायता, व्याख्या सेवा, र सहायक उपकरण तथा सेवा तपाईंको अनुरोधमा निःशुल्क रूपमा उपलब्ध छन्। उपलब्ध सेवाहरूमा मौखिक अनुवाद, लिखित अनुवाद, र सहायक उपकरणहरू समावेश छन्, तर यिनीसँग मात्र सीमित छैन। तपाईंले यी सेवाहरू र/वा सहायक सहायताहरू अनुरोध गर्न सक्नुहुन्छ; Medicaid Consumer Hotline 1-800-324-8680; मा कल गरेर; श्रवणशक्ति कमजोर भएका व्यक्तिहरूले TDD 7-1-1 मा कल गर्न सक्छन्।

Arabic

لمساعدتك في فهم هذا الإخطار، تتوفر خدمات المساعدة اللغوية وخدمات الترجمة الفورية والمساعدات الإضافية عند الطلب دون أي تكلفة. تشمل الخدمات المتاحة، على سبيل المثال لا الحصر: الترجمة الشفوية والترجمة التحريرية والمساعدات الإضافية. يمكنك طلب هذه الخدمات أو المساعدات الإضافية أو كليتهما عن طريق الاتصال بالخط الساخن للمستهلكين التابع لـ Medicaid على الرقم التالي 1-800-324-8680؛ وبوسع الأفراد الذين يعانون من ضعف السمع الاتصال بخدمة الهاتف النصي على الرقم التالي 7-1-1.

Haitian French Creole

Pou ede w konprann avi sa a, gen asistans lengwistik, sèvis entèpretasyon, èd oksilyè ak sèvis ki disponib gratis, lè ou fè demann pou sa. Sèvis ki disponib yo gen ladan yo, men se pa sa sèlman: tradiksyon oral, tradiksyon alekri ak èd oksilyè. Ou kapab mande sèvis sa yo ak/oswa èd oksilyè lè w rele Liy Asistans pou Konsomatè Medicaid la nan 1-800-324-8680; moun ki gen pwoblèm tande yo ka rele TDD 7-1-1.

Somali

Si lagaaga caawiyo inaad fahanto ogaysiiskan, kaalmada luqadda, adeegyada tarjumaada, iyo kaalmooyinka iyo adeegyada ayaa la heli karaa marka la codsado lacag la'aan adiga. Adeegyada la heli karo waxaa ka mid ah, laakiin aan ku xaddidnayn: tarjumaada afka, turjumaadda qoran, iyo qalabyada caawinta. Waxaad codsan kartaa adeegyadan iyo/ama caawimada caawimada adiga oo wacaya markaas Khadka Tooska ah ee Macmiilka Medicaid 1-800-324-8680; Shakhshiyaadka maqalka liidata waxay wici karaan TDD 7-1-1.

Ukrainian

Щоб допомогти вам зрозуміти зміст цього повідомлення, за запитом ви можете отримати безоплатну мовну допомогу, послуги усного перекладу, а також допоміжне обладнання та додаткові послуги. Доступні послуги включають, зокрема, усний переклад, письмовий переклад і допоміжне обладнання. Ви можете замовити ці послуги та/або допоміжне обладнання, зателефонувавши на гарячу лінію клієнтів Medicaid за номером 1-800-324-8680; для людей із вадами слуху працює номер TDD 7-1-1.

Russian

Чтобы помочь вам понять смысл этого уведомления, по запросу вы можете получить бесплатную языковую помощь, услуги устного перевода, а также вспомогательное оборудование и дополнительные услуги. Доступные услуги включают, в частности, устный перевод, письменный перевод и вспомогательное оборудование. Вы можете запросить эти услуги и/или вспомогательное оборудование, позвонив на горячую линию клиентов Medicaid по номеру 1-800-324-8680; для людей с нарушениями слуха предусмотрен номер TDD 7-1-1.

Swahili

Ili kukusaidia kuelewa notisi hii, usaidizi wa lugha, huduma za ukalimani, na visaidizi na huduma za ziada zinapatikana unapoomba bila gharama kwako. Huduma zinazopatikana ni pamoja na, lakini sio tu: tafsiri ya mdomo, tafsiri ya maandishi, na visaidizi vya ziada. Unaweza kuomba huduma hizi na/au visaidizi kwa kupiga simu ya Medicaid Consumer Hotline 1-800-324-8680; watu walio na ulemavu wa kusikia wanaweza kupiga simu TDD 7-1-1.

Kinyarwanda

Kugira ngo tugufashe gusobanukirwa iri tangazo, ubufasha bujyanye n'indimi, serivisi z'ubusemuzi, n'ibikoresho na serivisi bifasha abafite ubumuga mu kumva biraboneka nta kiguzi utanze iyo ubisabye. Serivisi ziboneka zikubiyemo, ariko si gusa: ubusemuzi mu mvugo, ubusemuzi mu nyandiko, n'ibikoresho bifasha abafite ubumuga mu kumva. Ushobora gusaba izi serivisi na/cyangwa ibikoresho bifasha abafite ubumuga mu kumva binyuze mu guhamagara Umurongo utishyurwa ufasha Abakiriya ba Medicaid 1-800-324-8680; abantu bafite ibibazo mu kumva bashobora guhamagara TDD 7-1-1.

French

Pour vous aider à comprendre cet avis, une assistance linguistique, des services d'interprétation et des aides et services auxiliaires sont disponibles sur demande et sans frais. Les services disponibles comprennent, sans toutefois s'y limiter, la traduction orale, la traduction écrite et les aides auxiliaires. Vous pouvez demander ces services et/ou des aides auxiliaires en appelant la Medicaid Consumer Hotline 1-800-324-8680 ; les personnes malentendantes peuvent appeler TDD 7-1-1.

Pashtu

ستاسو په دې خبرتیا د ښه درک کولو (پوهیدو) لپاره، د ژبې مرستې، د شفاهي ژباړې خدمتونه، او اضافي مرستندویه وسایل او خدمتونه ستاسو د غوښتنې پر بنسټ بې لګښته شتون لري. په شته خدماتو کې شفاهي ژباړه، په لیکلې ښه ژباړه، او مرستندویه وسایل شامل دي، خو یوازې په دې پورې محدود نه دي. تاسو کولی شئ د دې خدماتو او/یا مرستندویه وسایلو غوښتنه د میډیکایډ (Medicaid) د پېرودونکو ځانګړې د تلیفون شمېرې 1-800-324-8680 ته زنگ ووهلو له لارې وکړئ؛ هغه کسان چې د اورېدلو کمزورتیا لري کولی شي 7-1-1 TDD ته زنگ ووهي.

Dari

برای کمک به شما در درک این اطلاعات، کمک های زبانی، خدمات ترجمه شفاهی و کمک ها و خدمات اضافی بر اساس درخواست شما بطور رایگان برای شما ارائه می گردد. خدمات موجود شامل موارد ذیل میباشد، اما محدود به آنها نیست: ترجمه شفاهی، ترجمه کتبی و وسایل کمکی. شما می توانید این خدمات و/یا وسایل کمکی را با تماس با خط ویژه مصرف کنندگان Medicaid از طریق شماره 1-800-324-8680 درخواست دهید؛ افراد دارای اختلال شنوایی می توانند با شماره 7-1-1 TDD تماس بگیرند.

Uzbek

Bu bildirishnomani tushunishingizga yordam berish uchun so'rovingiz asosida bepul til yordamchi xizmatlari, og'zaki tarjima xizmatlari va qo'shimcha yordamchi vositalar taqdim etiladi. Mavjud xizmatlar qatoriga og'zaki tarjima, yozma tarjima hamda yordamchi vositalar kiradi. Siz ushbu xizmatlar va/yoki qo'shimcha yordamlar haqida Medicaid mijozlari uchun mo'ljallangan 1-800-324-8680 telefon raqamiga qo'ng'iroq qilib so'rashingiz mumkin; Eshitish qobiliyati cheklangan shaxslar TDD 7-1-1 raqami orqali bog'lanishlari mumkin.

Vietnamese

Để giúp bạn hiểu thông báo này, hỗ trợ ngôn ngữ, dịch vụ phiên dịch, phương tiện trợ giúp và dịch vụ phụ trợ được cung cấp miễn phí theo yêu cầu. Các dịch vụ có sẵn bao gồm, nhưng không giới hạn ở: dịch bằng lời nói, dịch bằng văn bản và phương tiện phụ trợ. Bạn có thể yêu cầu các dịch vụ này và/hoặc phương tiện phụ trợ bằng cách gọi tới Đường dây nóng cho Người tiêu dùng Medicaid theo số 1-800-324-8680; người khiếm thính có thể gọi TDD 7-1-1.

Tigrinya

ነዚ ምልክታ ከትርጉም ንክትገባኩም፡ ሓገዝ ቋንቋ፡ ኣገልግሎታት ትርጉም፡ ከምኡ'ውን ተወሰኹቲ ሓገዛትን ኣገልግሎታትን ኣብ ዝሓተትኩምዎ ብዘይ ክፍሊት ይርከቡ። ዘለው ኣገልግሎታት፡ ናይ ዘረባ ትርጉም፡ ናይ ጽሑፍ ትርጉምን ተወሰኹቲ ሓገዛትን ዘጠቓልሉ ከይኖሩ፡ በዚ ጥራሕ ዝድረቱ ኣይኮኑን። ናብ ምስመር ቴሌኮን ተጠቀምቲ ሜዲኬይድ (Medicaid Consumer Hotline) 1-800-324-8680 ብምድዋል፡ ነዞም ኣገልግሎታትን/ወይ ተወሰኹቲ ሓገዛት ክትሓቱ ትኽእሉ ኢኹም፤ ናይ ምስመሪ ጸገም ዘለዎም ውልቀ-ሰባት ናብ TDD 7-1-1 ክድውሉ ይኽእሉ እዮም።

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Name	Case Number	BMC Mailing Date
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State Hearing Request

If you want to appeal our decision, send the completed form to us by the deadline shown on page two (2) of this notice

Step 1: Sign and fill in the blanks.

I disagree with what you are doing or think you are making a mistake.

Sign Here: _____ Date: _____ Phone (____) _____

Step 2: *(Optional)* Complete this if someone else has already agreed to represent you *(a lawyer, social worker, friend, relative, etc.)*. If someone later agrees to represent you, tell us at that time.

The person who has agreed to represent me *(my Authorized representative)* is

Name		Phone Number	
Address	City	State	Zip Code
Fax Number	E-mail		

Step 3: Choose one of the following ways to send this request to us. We must receive the completed form by the deadline shown on page two (2) of this notice.

Mail only this page to us. Follow the steps on the back of this page. Please keep a photocopy of your completed request for your records.

Or

Fax only this side of this page to the ODJFS Bureau of State Hearings at (614) 728-9574. *Please keep proof of faxing, and your completed request, for your records.*

Or

E-mail to the ODJFS Bureau of State Hearings < bsh@odjfs.state.oh.us >. Please include the phrase *"State Hearing Request, BMC"* **in the subject box**. Please include in the message box: all the information in box at the top of the first page of this notice, and all of the information from Step two (2) of this page if applicable.

Please keep a copy of your e-mail for your records.

Or

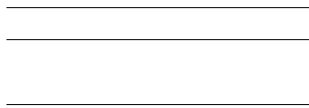
Phone the ODJFS Consumer Access Line at 1-866-635-3748 (1-866-ODJFS-4-U) and follow instructions for State Hearings. **Mention this notice. Only you may phone. Please keep a record of your call, including the date you called and the name of the person with whom you spoke.**

Or

Go to <https://hearings.jfs.ohio.gov/SHARE> to request a State Hearing.

Mailing Steps:

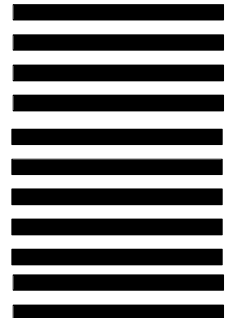
- (1) Fold this page only along the dotted lines.
- (2) Tape after folding.



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OHIO DEPT OF JOB AND FAMILY SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43272-5376