pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Notice of Service Determination and the Right to Appeal

Date this notice was mailed or hand-delivered to you:

SECTION I - PARTICIPANT INFORMATION

Participant Name:

Participant Address:

SECTION II - SERVICE DETERMINATION

On (insert date) the (insert SC agency) made the following service delivery determination:

Program:

You are currently eligible and enrolled in the program checked below:

☐ Aging Waiver (810) ☐ AIDS Waiver (940) ☐ Attendant Care Waiver (860) ☐ COMMCARE Waiver (864)

☐ Independence Waiver (861) ☐ OBRA Waiver (861) ☐ Act 150

Service Determination:

Your service delivery determination:

☐ Denial of: (identify specific service(s) being denied)

☐ Reduction of: (identify service(s) being reduced and the effective date)

☐ Termination of: (identify service(s) terminated and the effective date)

☐ Suspension of: (identify specific service(s) suspended and the effective date)

☐ Act 150 fee computation: _____

Reason for Service Determination:

This decision has been made based on the following reason(s), including any departmental policy and/or regulation:

Questions and Concerns:

If you have any questions or concerns regarding this notice, please contact:

Service coordinator: Telephone number:

SECTION III - APPEAL RIGHTS AND INSTRUCTIONS

- You have the right to appeal if you are dissatisfied with any decision to deny, reduce, terminate or suspend service provided to you under the Medicaid Waiver or Home and Community-Based Services program.
- You have the right to appeal if you are denied the willing and enrolled provider of your choice.
- You have the right to appeal the computation of the fee amount for Act 150 services, but not the fee itself.
- You will **not** be granted a hearing if the action taken was solely by state or federal law or regulation requiring a change in the type of services available under the waiver program.

Representation:

You have the right to represent yourself **or** to have someone else represent you. A staff member of the (insert SC agency) (NAME OF SC AGENCY) will refer you to agencies that may be able to provide legal help if you so request. During the appeal process, you or your representative can present the reasons why you think the proposed action is incorrect and present evidence and/or witnesses to support your case.

You may consult with family members and/or an attorney for assistance in determining whether to appeal. For some participants, the long-term care ombudsman may serve as a point of contact in providing you with information and assistance regarding your rights and the fair hearings and appeals process.

You or your representative has the right to examine all information that will be introduced at the hearing, as well as other information in your case file that is not exempt under 55 Pa. Code § 105.5(b). There may be a charge for copies of these documents.

How to Appeal:

If you decide to appeal, you must submit your request to (insert SC agency) (NAME OF SC AGENCY) within 30 calendar days of the date of this notice.

Your request must be postmarked on or before (insert date) DATE which is 30 calendar days following the date of this notice.

If you are currently receiving services and your appeal request is postmarked or received by (insert date) DATE (which is within 10 calendar days of the date of this notice), you will continue to receive services at the current level pending the outcome of the hearing. However, if your appeal is postmarked after this date, your services will change as shown in Section II.

Your appeal must be in writing as follows:

Fill out Section IV and sign Section V of this form; keep a copy for your records.

- Give the reason for your appeal **and**
- Give your telephone number **and**
- Give your exact address **and**

Mail or take all pages of this form to the agency at the following address:

Insert Agency Address In This Space

SECTION IV - REQUEST TO APPEAL

Reason for Appeal:

What is the reason(s) for your appeal? Please specify:

(You may attach additional supporting documentation or information. Use additional paper if necessary.)

Resolution Being Sought:

What outcome would you like? Please specify:

(Use additional paper if necessary.)

Type of Hearing:

The Bureau of Hearings and Appeals at the Department of Public Welfare will hold a hearing for you either over the telephone or face-to-face. You may choose which type of hearing you want. If you do not have a telephone in your home and cannot get to one (for example, a friend or relative's telephone), you may go to the telephone hearing at your local agency or at a site approved by the local agency. If you wish to have a face-to-face hearing, you must make such a request when you file your appeal. A face-to-face hearing will be scheduled for you at the closest available location. Transportation cost for a face-to-face hearing is the responsibility of the participant.

Type of Hearing (check one): ☐ Telephone hearing ☐ Face-to-face hearing

If you request a face-to-face hearing and you require reasonable accommodations, please describe:

(Use additional paper if necessary.)

Interpreter Services:

If you speak a language other than English or need an alternative form of communication or if you need an interpreter, you may request help in obtaining an interpreter. You must make that request in advance of the hearing. There will be no cost to you for this service.

Check if you need an interpreter: ☐ What language? _____

Check if you need an alternative form of communication: ☐ If so, please specify: _____

SECTION V - SIGNATURES

This section is to be completed by the participant or the participant's representative. Sign this form only if you disagree with the services and want to appeal.

Participant:

Date _____ Participant Signature _____ Telephone Number _____

Participant Address _____

Participant's Representative (if applicable):

Date _____ Representative Signature _____ Telephone Number _____

Representative Address _____

Relationship to participant _____

SECTION VI - AGENCY USE ONLY

Form Distribution:

Upon receipt of appeal request from participant, service coordination agencies must, within three working days, mail a hard copy of this completed form and a hard copy of the completed Bureau of Hearings and Appeals agency cover sheet to the Bureau of Hearings and Appeals regional office, based on the participant's county of residence.

Additionally, you must email a copy of this form to the Office of Long-Term Living within three working days at: ra-oltlappeals@pa.gov.