ADVERSE ACTION NOTICE

DATE THIS NOTICE WAS ISSUED: _____

CONSUMER INFORMATION

CONSUMER NAME: _____

ADDRESS: _____

_____

SERVICE DETERMINATION

On _____ (*insert date MM/DD/YYYY*) the _____ Area Agency on Aging completed a detailed assessment of your needs. Based on the information received during this process it has been identified that:

A. Programs:

You are enrolled in:

- ☐ OPTIONS program
- ☐ Caregiver Support Program
- ☐ Domiciliary Care Program
- ☐ Home Delivered Meals
- ☐ Other _____

B. Action:

The Area Agency on Aging has made the following service delivery determination:

- ☐ Denial of (*identify specific request that is being denied*).
- ☐ Reduction of (*identify service that is being reduced)* on *(the effective date*),
- ☐ Termination of (*identify service(s) terminated)* on *(the effective date)*
- ☐ Other _____

C. Reason for Action:

This decision has been made based on the following information: (*AAA is to provide a detailed description of the information that was used to make the decision to deny, reduce or terminate services. When appropriate include a citation of the regulation or requirement that supports the decision.)*

Should you choose to appeal this decision you are agreeing to participate in the Informal Complaint Process. The AAA is required to respond to your appeal request in writing within ten (10) working days of receipt of this request. If you disagree with AAA's recommended resolution you have the right to request an appeal to the Secretary of the Department of Aging and receive a Formal Hearing. Information on the Formal Hearing Process will be provided to you by the AAA.

D. Questions and Concerns:

If you have any questions or concerns regarding this notice, please contact _____(*name of care manager*) at _____(*telephone number*). If you believe that your assessment or care plan may adversely affect you, you do have the right to appeal

APPEAL RIGHTS and INSTRUCTIONS ON HOW TO APPEAL

APPEAL RIGHTS

A. Rights:

- You have the right to appeal any action or failure to act by your providing AAA.
- You also have the right to appeal if you are dissatisfied with any decision to deny, reduce or terminate service provided to you by the Area Agency on Aging.

- You will **not** be granted a hearing:

    - If the action taken was caused solely by State or Federal law or regulation requiring a change in the type of services available under the program, **or**
    - If you participate in the OPTIONS Program and were terminated from services due to failure to participate in the cost sharing system.

Note: The AAA is not required to consider a denial of service appeals if you were placed on a waiting list when services could not be provided due to lack of resources.

B. Representation:

You have the right to represent yourself **or** to have someone else represent you. A staff member of the _____Area Agency on Aging will refer you for 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.

C. Assistive Services Needed:

If you speak a language other than English or have problems in communicating or if you need an interpreter, you may request help in obtaining an interpreter, but 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? _____

Other assistance needed? Explain _____

INSTRUCTIONS

You are free to consult with family members, your attorney, and/or the Long-Term Care Ombudsman at (*AAA's name, address and telephone number*) for assistance in determining whether to appeal. 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.

If you decide to appeal, you must submit your request to the Director/Administrator of the _____ Area Agency on Aging **within thirty (30) days** of the date of this notification.

For help in completing the forms to request an appeal, you may contact the AAA at _____.

Your appeal must be in writing as follows:

Fill out and sign one copy of this form; keep a copy for your records.

On Page 5 and 6 below you will:

- Give the reason for your appeal **and**
- Explain the resolution you are seeking **and**
- Give your name and telephone number **and**
- Give your exact address

Mail or take this entire form to the AAA at the following address:

(*Insert AAA Address In This Space)*

REQUEST TO APPEAL

I WANT TO APPEAL BECAUSE SERVICES ARE BEING: (Check all that apply)

- ☐ DENIED
- ☐ TERMINATED
- ☐ REDUCED
- ☐ OTHER (Please specify) _____

Reason for Appeal:

What is the reason(s) for your appeal? Please specify all relevant facts and the grounds for the appeal.

(Please 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)

SIGNATURES

This section is to be completed by the consumer <u>or</u> the consumer's representative

Consumer:

DATE	CONSUMER SIGNATURE	TELEPHONE NO.

CONSUMER ADDRESS

Consumer's Representative:

DATE	REPRESENTATIVE SIGNATURE	TELEPHONE NO.

REPRESENTATIVE ADDRESS

RELATIONSHIP TO THE CONSUMER