ADVERSE ACTION NOTICE

DATE THIS NOTICE WAS ISSUED: _____

PROVIDER/LEGAL ENTITY INFORMATION

PROVIDER/LEGAL ENTITIY NAME: _____

ADDRESS: _____

_____

DETERMINATION

On _____ (*insert date MM/DD/YYYY*) the _____ Area Agency on Aging completed a _____ (*indicate the activity conducted, example, review of RFP, provider monitoring visit, rate negotiation*). Based on the information received during this process it has been identified that:

A. Action:

The Area Agency on Aging has made the following determination:

- ☐ Denial of *(identify what is being denied).*
- ☐ Termination of *(identify what is being terminated)* on *(the effective date)*
- ☐ OTHER (Please specify) _____

B. 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 or terminate the provider. Include a citation of the regulations or requirements that support 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 <u>ten (10) working days</u> 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.

C. <u>Questions and Concerns</u>:

If you have any questions or concerns regarding this notice, please contact _____ (name of contract monitor), at _____ (telephone number). If you believe that this determination may adversely affect you, you do have the right to appeal.

APPEAL RIGHTS and INSTRUCTIONS ON HOW TO APPEAL

APPEAL RIGHTS

A. Rights:

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 are a provider for consumers in the OPTIONS Program and your contract was terminated due to non-compliance with or termination of State or Federal certification or licensure.

B. Representation:

You have the right to represent yourself **or** to have someone else represent you. 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 an attorney for assistance in determining whether to appeal. 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.

What assistance will you need? _____

INSTRUCTIONS

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.

Your appeal must be in writing as follows:

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

On Pages 4 and 5 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

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 Provider or Legal Entity:

PROVIDER:

DATE | PROVIDER NAME | TELEPHONE NO.

PROVIDER ADDRESS

PROVIDER CONTACT | E-MAIL ADDRESS

LEGAL ENTITY :

DATE | LEGAL ENTITY NAME | TELEPHONE NO.

LEGAL ENTITY ADDRESS

LEGAL ENTITY CONTACT | E-MAIL ADDRESS