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. <u>Programs:</u>
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 (<i>identify specific request that is being denied</i>).
□ Reduction of (<i>identify service that is being reduced</i>) 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 hav	e any	questions or	concerns r	egarding tl	his notic	ce, pleas	se contact	:(/	name	of care	e
<u>manager)</u>	at	-	(telephone	number).	If you	believe	that your	assessment	or ca	re plai	n
may adve	rsely a	affect you, yo	u do have th	ne right to a	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 in	correct 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 at (<i>AAA's name, address and telephone number</i>) for assistance in determining whether The Long-Term Care Ombudsman may serve as a point of contact in providing you with and assistance regarding your rights and the fair hearings and appeals process.	to appeal.
If you decide to appeal, you must submit your request to the Director/Administrator of th Area Agency on Aging within thirty (30) days of the date of this	
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 <u>and</u> Explain the resolution you are seeking <u>and</u> Give your name and telephone number <u>and</u> 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:	

Vhat is the reppeal.	eason(s) for y	our appeal?	Please specif	y all relevant	facts and	the grounds	for the
Please attach	additional su	pporting docu	mentation or in	formation. Us	e additional	paper if nece	essary)
Resolution Be	eing Sought:						
Vhat outcome	would you lik	e? Please sp	ecify:				
				(Us	se additiona	l paper if nec	essary)
GNATURES							
his section i	s to be comp	leted by the	consumer <u>or</u> t	he consume	's represe	ntative	

DATE	CONSUMER SIGNATURE	TELEPHONE N
	CONSUMER ADDRESS	
mer's Represer	ntative:	
DATE	REPRESENTATIVE SIGNATURE	TELEPHONE N
DATE	REPRESENTATIVE SIGNATURE REPRESENTATIVE ADDRESS	TELEPHONE N