INSTRUCTIONS • FAIR HEARING REQUEST FORM

If you are applying for Waiver services or services in an Intermediate Care Facility for persons with an Intellectual Disability (ICF/ID), or if you object to an action taken by the Administrative Entity (AE), County Program, or the Office of Developmental Programs (ODP) that adversely affects your claim or authorization for Waiver services, you have the right to a Fair Hearing before the Department of Human Services, Bureau of Hearings and Appeals (BHA). You may request a Fair Hearing in the following circumstances:

- You are determined likely to meet an ICF/ID or ICF/ORC level of care and are enrolled to receive Medical Assistance but are not given the opportunity to express a service delivery preference for either Waiver or ICF/ID services.
- You are denied your preference of Waiver, TSM, or ICF/ID services.
- Based on a referral from the AE or County Program, a Qualified Developmental Disability Professional (QDDP) determines that you do not require an ICF/ID or ICF/ORC level of care and eligibility for services denied or terminated.
- You are denied Waiver service(s) of your choice, including the amount, duration, and scope of service(s).
- You are denied the choice of willing and qualified Waiver or TSM provider(s).
- A decision or an action is taken to deny, suspend, reduce, or terminate a Waiver service authorized on your Individual Support Plan (ISP).

FILING THE FAIR HEARING REQUEST/APPEAL:

You have the right to file a Fair Hearing request directly with the agency that made the determination affecting your claim or authorization for Waiver, TSM, or ICF/ID services (the County Program, AE, or ODP). You have a right to appeal any adverse action and to have a hearing if you are dissatisfied with any decision to deny, suspend, reduce, or terminate Waiver services, Form DP 458 (attached) must be used to file your appeal.

TO: The AE or County Program that made the determination affecting your claim or authorization for Waiver, TSM, or ICF/ID services should complete the TO section of the DP 458 form and send the form to you with the written notice of determination. If you did not receive a DP 458 form from the AE or County Program or the TO section was not completed, please fill this section in with the name and address of the entity (the AE, County Program, or ODP) that made the determination.

Please remember: All Fair Hearing requests/appeals must be sent directly to the agency that made the determination regarding your claim or authorization for Waiver, TSM, or ICF/ID services.

FROM: The appellant is the person whom the determination directly impacts. While a surrogate can fill out the DP 458 form on behalf of the appellant, this section should be completed with the appellant's information.

I REQUEST THIS APPEAL BASED ON THE FOLLOWING ACTIONS: Write or type the reason for your appeal. This should be based on the written notice provided by the AE, County Program, or ODP outlining the determination that affected your claim or authorization for Waiver, TSM, or ICF/ID services. If you did not receive a written notice, summarize the determination that was provided to you verbally.

I REQUEST THE FOLLOWING REMEDIES TO RESOLVE THIS APPEAL: Write or type the actions that you would like to see happen to resolve the issue that is being appealed.

NAME OF INDIVIDUAL'S SURROGATE, SURROGATE'S MAILING ADDRESS, SURROGATE'S DAY TELEPHONE NUMBER, SURROGATE'S RELATIONSHIP TO APPELLANT: If a surrogate is completing this form on behalf of the appellant, this information should be filled in.

PLEASE CHECK THE BOX NEXT TO THE TYPE OF HEARING YOU WANT: BHA will conduct a hearing for you over the telephone or face-to-face. Please check the appropriate box to indicate the type of hearing you want to occur.

- Telephone hearings: If you do not have a telephone that can be used to conduct this hearing, you may use a telephone at the County MH/ID Program, AE office, ODP office, or the telephone of a friend, relative, or neighbor. Please indicate the telephone number where all parties may be reached to conduct a hearing.
- Face-to-face hearings: This type of hearing is held in one of the following locations: Erie, Harrisburg, Philadelphia, Pittsburgh, Plymouth, or Reading. More information on the exact location of the hearing site will be sent to you and the AE, County Program, or ODP if you request a face-to-face hearing. A second option is also available to the appellant for face-to-face hearings in which the appellant and the Administrative Law Judge will be at BHA and the AE, County Program, or ODP will participate via telephone.

FOR THE HEARING: If you need accommodations to attend or participate in the hearing, please indicate the specific accommodations required (language interpreter, communication device, etc.) on the DP 458 form when you file your Fair Hearing request/appeal. All requests for assistance in obtaining an accommodation must be made in advance of the hearing. Please contact the County Program, AE, ODP, or BHA to request assistance. You may also supply your own interpreter or bring your own communication device, etc., to the hearing.

SIGNATURES: All DP 458 forms must contain the signature of the appellant or his or her surrogate when the appeal is filed. If the signature or mark is missing from the DP 458 form, BHA will contact the appellant or surrogate directly to obtain the required signature or mark. If the appellant does not have a surrogate and is unable to sign the form, the following alternatives are acceptable.

- The appellant may make a mark on the signature line. If this method is utilized, two witnesses should also sign the form at that time.
- If the appellant is unable to sign or make a mark, then the signature line should state "unable to sign or make a mark" and two witnesses should also sign the form at that time.

Once the AE, County Program, or ODP has received the DP 458 form, they will forward it to the appropriate BHA regional office.

APPEAL TIME FRAME FOR THE CONTINUATION OF WAIVER SERVICES:

If you are appealing a change (that is, reduction, termination, or suspension) in current Waiver services that are authorized in your ISP and you want those Waiver services to continue without change during the appeal process, you must complete the DP 458 form and send it to the agency that made the determination adversely affecting your authorization of claim for services within **10 DAYS** of the mailing date of the AE's or ODP's written notification of the decision to change your Waiver services. (Please note that ODP's notification will be sent via PROMISe™ versus a letter sent from the AE.)

APPEAL TIME FRAME WHERE THE CONTINUATION OF WAIVER SERVICES IS NOT INVOLVED:

Services that are denied without first being authorized in the ISP cannot be provided pending appeal. There may also be instances when you do not desire to have your current level of Waiver services continue until a decision is reached at the fair hearing. In these situations, as well as for actions taken regarding Waiver service delivery preference or TSM eligibility, you are afforded **30 calendar days** to appeal the denial, reduction, suspension, or change. Form DP 458 must be completed and submitted to the agency that made the determination adversely affecting your authorization or claim for services within **30 calendar days** of the mailing date of the written notification of the decision or action.

APPEAL TIMEFRAME WHERE NO WRITTEN NOTICE WAS PROVIDED:

The County Program, AE and ODP are required to provide written notice of any determination made by the agency that adversely affects your authorization or claim for services. If an agency initiates an action on Waiver or TSM services or verbally denies a request for new or a change to your current Waiver services without providing written notice, you have 6 calendar months from the effective date of the action or verbal notification to request a fair hearing. When this appeal is filed, any terminated or reduced services will be reinstated retroactively (if possible) to the date of discontinuance and to the level provided on the date of the action. These services will continue until an adverse decision is rendered after the fair hearing.

PRE-HEARING CONFERENCES:

In addition to filing a Fair Hearing request/appeal, you may choose to have a pre-hearing conference with the agency that made the determination adversely affecting your authorization or claim for Waiver, TSM, or ICF/ID services (the County Program, AE, or ODP) without forfeiting your appeal rights. If you wish to have a pre-hearing conference, please contact the agency that made the determination immediately upon receipt of your written notice of the adverse decision or action. A pre-hearing conference is optimal for you and must occur before the scheduled Fair Hearing.

CONTACT INFORMATION:

If you want a pre-hearing conference to discuss your concerns, or if you need assistance to file a Fair Hearing request/appeal, please contact the AE, County Program, or ODP designee listed below (when the form is completed by the entity listed):

NAME:	ADDRESS:
TELEPHONE NUMBER: ( )	

The designee will then photocopy the completed DP 458 form and send a copy to you and the appropriate ODP regional office and central office. ODP regional and central office addresses and contact information can be accessed at:

http://www.dhs.pa.gov/learnaboutdhs/helpfultelephonenumbers/regionaldevelopmentalprogramfieldoffices/index.htm

The Department of Human Services, BHA contact information can be accessed at:

http://www.dpw.state.pa.us/findfacilsandlocs/bureauofhearingsandappealsregionaloffices/index.htm

REPRESENTATION AT THE HEARING:

You have the right to represent yourself at the hearing. You may present the reasons why you disagree with the action or decision to the BHA Administrative Law Judge presiding over the hearing. You may also present evidence and witnesses to support your case.

You also have the right to have someone else represent you. If you need legal counsel, a list of legal aid offices is attached. If you request additional help, the designee will refer you to advocacy organizations in your community.

QUESTIONS:

If you have any questions regarding the completion of the DP 458 form or the information contained in these instructions, please contact your AE, County Program, or Supports Coordinator. You may also contact the ODP Customer Service line at **1-888-565-9435.** Toll-free TTY number (telephone for hearing impaired only): 1-866-388-1114. Local telephone: 717-265-7427. A customer service member will answer calls during normal business hours, which are 8:30 a.m. to 4:00 p.m. EST, Monday through Friday.

OFFICE OF DEVELOPMENTAL PROGRAMS
INTELLECTUAL DISABILITY/AUTISM WAIVERS, TARGETED SUPPORT MANAGEMENT, OR INTERMEDIATE CARE FACILITIES

FAIR HEARING REQUEST FORM

TO:

COMPLETED BY ENTITY THAT MADE DECISION IMPACTING SERVICES/ELIGIBILITY OR APPELLANT IF NOT COMPLETED BY ENTITY
AE/COUNTY/ODP:
STREET ADDRESS:
CITY/STATE/ZIP:
DATE APPEAL RECEIVED:

FROM:

COMPLETED BY APPELLANT/SURROGATE
NAME OF APPELLANT:
STREET ADDRESS:
CITY/STATE/ZIP:
DAY TELEPHONE NUMBER:
MEDICAID RECIPIENT NUMBER:

I hereby request a Fair Hearing before the Department of Human Services, Bureau of Hearings and Appeals. I am requesting this appeal on behalf of myself or the appellant listed above who is applying for or receiving services through the Consolidated, Person/Family Directed Support or Community Living Waiver.

I REQUEST THIS APPEAL BASED ON THE FOLLOWING ACTIONS (YOU MAY ATTACH MORE PAGES IF NEEDED):	
I REQUEST THE FOLLOWING REMEDIES TO RESOLVE THIS APPEAL (EXPLAIN):	
NAME OF APPELLANT'S SURROGATE (IF APPLICABLE):	
SURROGATE'S MAILING ADDRESS (IF APPLICABLE):	
SURROGATE'S DAY TELEPHONE NUMBER:	SURROGATE'S RELATIONSHIP TO APPELLANT:

Please check the box next to the type of hearing you want:

☐ I want a telephone hearing. I and my witnesses and anyone helping me will be at this phone number: _____

☐ I want a telephone hearing. I and my witnesses and anyone helping me will be at the following (check one):

☐ Administrative Entity (AE) ☐ County program ☐ ODP

☐ I want a face-to-face hearing. I and my witnesses and anyone helping me will be in the hearing room with the judge and AE/county program/ODP staff.

☐ I want a face-to-face hearing. I and my witnesses and anyone helping me will be in the hearing room with the judge. The AE/county program/ODP staff will be on the phone.

For the hearing:

☐ Please check if you need special help because of a hearing impairment or disability.

Describe: _____

☐ Please check if you need an interpreter. There will be no cost to you. What language? _____

Signatures:

APPELLANT (REQUIRED):	DATE:
WITNESS (IF APPELLANT MAKES A MARK):	WITNESS IF APPELLANT MAKES A MARK):
SURROGATE (IF APPLICABLE):	DATE:

ONCE THE AE/COUNTY PROGRAM/ODP HAS RECEIVED THIS APPEAL, THEY WILL FORWARD IT TO THE APPROPRIATE REGIONAL OFFICE OF THE BUREAU OF HEARINGS AND APPEALS AS LISTED AT:

www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeofadministration/bureauofhearingsandappeals/index.htm