



**NOTICE OF ACTION**  
State Form 46015 (R5 / 7-01) / HCBS 0005

**NOTICE**  
See the back of this form for important information  
about your responsibilities and appeal rights.

- Aged or Disabled     Autism     ICF / MR     Medically Fragile Children     TBI     AL     AFC

Name	Medicaid number
Address	County
City, state, ZIP code	Mailing date of notice (month, day, year)

- NEW APPLICATION**     **ANNUAL REDETERMINATION**     **CHANGE / UPDATE**

The Indiana Family and Social Services Administration has taken the action indicated below in regard to your application for, or change of, services under the Home and Community-Based Services (HCBS) Waiver Program.

FOR APPLICATION ONLY	
Effective _____, your application for services is:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Level of Care	<input type="checkbox"/> NF / Intermediate <input type="checkbox"/> NF / Skilled <input type="checkbox"/> ICF / MR <input type="checkbox"/> Hospital <input type="checkbox"/> NF/TBI <input type="checkbox"/> NF/AL <input type="checkbox"/> NF/AFC
Reason	
Please check who approved Level of Care: <input type="checkbox"/> State <input type="checkbox"/> AAA	

FOR ANNUAL REDETERMINATION, CHANGE / UPDATE, AND DISCONTINUANCE ONLY	
Effective _____, your waiver for services are:	<input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Continued at same amount <input type="checkbox"/> Discontinued
Reason	
Description of change	
Redetermination of Level of Care completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	By: <input type="checkbox"/> State <input type="checkbox"/> AAA <input type="checkbox"/> Indep. C.M.

SERVICES APPROVED					
PROVIDER - SPECIFY NAME AND ADDRESS	SERVICE	START DATE	STOP DATE	TOTAL HOURS	AVE. HRS / MO.
	Case Management				
Signature of case manager		Case manager's 9 digit authorization number		Date (month, day, year)	
Address		Case Mgr's 4 digit I.D. number		Telephone number (    )	

**IF YOU WISH TO APPEAL, PLEASE READ THE INFORMATION ON PAGE 2 AND THEN SIGN AND DATE BELOW.**

<input type="checkbox"/> I wish to appeal the above decision.	Reason:
Signature of applicant / recipient / guardian	
Date (month, day, year)	

## YOUR APPEAL RIGHTS AS AN HCBS WAIVER SERVICES RECIPIENT

1. If you question the above action, you should discuss this matter with your waiver services case manager.

**2. Your Right to Appeal and Have a Fair Hearing:**

If your application is denied, you may file an appeal within 30 days of the date the notice is **mailed** to you.

As an HCBS waiver recipient, if you disagree with any action taken on your HCBS waiver case, you may appeal within 30 days of the **effective date** of the action. However, your HCBS waiver benefits will not continue unless you appeal **prior** to the effective date of action. If you appeal and your waiver benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the hearing decision.

**3. How to Request an Appeal:**

If you wish to appeal this decision, you may request an appeal within 30 days of the date of receipt of this decision. Sign and return this form **or** send a letter with your signature to: MS04, Indiana Family and Social Services Administration, Hearings and Appeals, 402 W. Washington St., Room W392, Indianapolis, IN 46204

If you send a letter rather than this Notice of Action, be sure that the letter contains your full name, address, and telephone number where you can be reached. Please attach a copy of this decision and state the name of the action you are appealing. If you are unable to write this letter, you may have someone assist you in requesting this appeal. A telephone request for an appeal cannot be accepted.

You will be notified in writing by the Family and Social Services Administration, Hearings and Appeals of the date, time, and place for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the waiver case manager.

You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.

**Distribution of Notice of Action:**

- Recipient       County DFC       Assessment Agency       Provider(s)       Waiver Case File  
 BDDS Case File     AAA Case File       Other \_\_\_\_\_