Mike Braun, Governor
State of Indiana

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
402 W. WASHINGTON ST., ROOM W374, MS07
INDIANAPOLIS, IN 46207

Office of Medicaid Policy and Planning
PATHWAYS Medicaid Waiver Letter of Invitation

DATE

Case: AssessmentPro ID

Name of Individual
Address 1
City, State, ZIP

RE: **Invitation to pursue supports through the PathWays Medicaid Waiver**

Dear NAME,

We are pleased to inform you that **you are being invited to pursue the PathWays Medicaid Waiver** and are no longer on the waiting list.

You must notify your Managed Care Entity (MCE) of your decision within 30 days from the date of this letter. Please follow the instructions for your response that are enclosed with this letter. The MCE will attempt to contact you four times during this 30 day period. **If the MCE does not receive a response from you, this invitation will be rescinded and you will not be placed back on the waiting list**. Your participation in this process is very important. The instructions for your response are enclosed with this letter. You will be asked to provide information and make decisions within certain timeframes.

You must complete all the required steps within 180 days from the date of this letter to obtain services on the PathWays Medicaid Waiver. This invitation will be rescinded if you do not complete the required steps to become eligible for and active on the waiver by XXXX. You are not currently on the waiting list and may reapply at any time.

If you disagree with this action, you have a right to appeal by following the procedures in the attached appeal rights. If you have any questions or concerns, please contact your Managed Care Entity (MCE) which is XXXX via phone at XXXX or in person at: address.

Keep this letter in a safe place with your important documents.

Sincerely,

E. Mitchell Roob, Jr., Interim Director, Office of Medicaid Policy and Planning

Enclosure: Appeal Rights

INSTRUCTIONS FOR RESPONDING TO THIS INVITATION

OPTION 1:
COMPLETE AND SUBMIT THE RESPONSE FORM FOR THE PATHWAYS WAIVER

1. Fill out the Response Form to indicate your interest in receiving services.

    A. **Check "YES"** if you are still interested in the PathWays Waiver

    B. **Check "NO"** if you are no longer interested in the PathWays Waiver.

2. **Sign the Response Form.**

3. **Return the Response Form by XXXX.**

    FAX the form to: XXXX OR MAIL to:
    MCE
    Address

If you are interested in the PathWays Waiver, a representative from your Managed Care Entity (MCE) will contact you to schedule a meeting after you return the form.

OPTION 2:
CONTACT YOUR LOCAL MANAGED CARE ENTITY (MCE) WHICH IS XXXX VIA PHONE AT XXXX **OR IN PERSON AT:** MCE address **FOR THE PATHWAYS WAIVER**

PATHWAYS WAIVER RESPONSE FORM

Please complete this form to notify Managed Care Entity (MCE) of your interest in receiving waiver services on the **PathWays Waiver**.

PLEASE PRINT CLEARLY

Name of the individual to receive waiver services:											
Social Security Number:				-			-				
Address:											
City:				State:				Zip:			
Phone Number:				Email:							
Signature of individual (or parent/legal guardian):											

SELECT ONE (1) OPTION – "YES" or "NO"

YES

☐ **YES, I am interested in receiving supports through the PathWays Waiver and would like to begin the intake process. If YES, also select one (1) "YES" option below:**

- ☐ **YES, and I am currently receiving Indiana Medicaid.**
- ☐ **YES, and I have applied for Indiana Medicaid.**
- ☐ **YES, but I have not applied for Indiana Medicaid.**

Once we receive your "YES" response, your MCE will contact you to assist you with the required steps to obtain waiver services.

NO

☐ **NO, I am not interested in receiving supports through the PathWays Waiver. I understand I am no longer on the waiting list for the PathWays Waiver.**

PLEASE SEND THIS COMPLETED FORM TO:
Name of Managed Care Entity
Address
Or FAX to: XXXX

Case: AssessmentPro ID

Appeal Rights for Home and Community-Based Services

You have the right to appeal the enclosed decision and have a fair hearing. The enclosed letter explains the decision regarding your application for or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a fair hearing.

How to request an appeal:
Your request for an appeal must be received by close of business no later than 30 days from the date of the enclosed letter. You must also list with reasonable particularity the reason(s) for requesting the appeal.

To file an appeal, please sign, date and return this form to:

AOPA Appeals
FSSA Office of General Counsel
MS 27
402 W. Washington Street, Room W451
Indianapolis, IN 46204

Or send the form via fax to:
(317) 232-1133

If you are unable to sign and date this form, you may have someone assist you.

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

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

I wish to appeal the above decision for the following reasons:

RE: Invitation to pursue supports through the PathWays Home and Community-based Services (HCBS) Waiver

If you require more space, include additional pages.

Name of Applicant: _____

Signature of Applicant/Guardian: _____

Date: _____ Reference: AssessmentPro ID

This is considered an administrative action by the State of Indiana appealable to an administrative law judge from the State of Indiana Office of Administrative Law Proceedings.