Mike Braun, Governor
State of Indiana

Indiana Family and Social Services Administration
Division of Disability and Rehabilitative Services

402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083
800-545-7763

Bureau of Disabilities Services
HEALTH AND WELLNESS Waiver Letter of Invitation

DATE

Case: C-CaMSS Case ID

Name of Individual
Address 1
City, State, ZIP

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

Dear NAME,

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

You must notify your local Area Agency on Aging (AAA) 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 AAA will attempt to contact you four times within the 30-day period. **If the AAA does not receive a response from you within the 30-day timeframe, this invitation will be rescinded and you will not be placed back on the waiting list.** Your participation in this process is very important.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 will need to have Medicaid to access the Health and Wellness Waiver. If you do not currently receive Medicaid, you can apply at https://fssabenefits.in.gov/bp/#/ or you can speak with your Options Counselor prior to applying for Medicaid.

If you accept this invitation within the 30-day timeframe, you must complete all the required steps within 180 days from the date of this letter to obtain services on the Health and Wellness 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 This invitation will be rescinded if you do not complete the required steps to become eligible for and active on the waiver by XXXX.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 local Area Agency on Aging (AAA) Office via phone at XXXX or in person at: AAA address.

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

Sincerely,

Kelly C. Mitchell
Director, Division of Disability & Rehabilitative Services

Enclosure: Appeal Rights
cc: File

INSTRUCTIONS FOR RESPONDING TO THIS INVITATION

OPTION 1:
COMPLETE AND SUBMIT THE RESPONSE FORM FOR THE HEALTH AND WELLNESS WAIVER

1. Fill out the Response Form to indicate your interest in receiving services.
    A. **Check "YES"** if you are still interested in the Health and Wellness Waiver
    B. **Check "NO"** if you are no longer interested in the Health and Wellness Waiver.
2. **Sign the Response Form**.
3. **Return the Response Form within the next 30 days**, which is by XXXX.

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

If you are interested in the Health and Wellness Waiver, an Options Counselor from your Area Agency on Aging (AAA) office will contact you to schedule a meeting after you return the form.

If you do not currently receive Medicaid, you will need to have Medicaid to access the Health and Wellness Waiver. You can apply for Medicaid at https://fssabenefits.in.gov/bp/#/ or you can wait to speak with your Options Counselor prior to applying for Medicaid.

OPTION 2:
CONTACT YOUR LOCAL AREA AGENCY ON AGING (AAA) OFFICE VIA PHONE AT XXXX OR IN PERSON AT: AAA address FOR THE HEALTH AND WELLNESS WAIVER

If you do not currently receive Medicaid, you will need to have Medicaid to access the Health and Wellness Waiver. You can apply for Medicaid at https://fssabenefits.in.gov/bp/#/ or you can wait to speak with your Options Counselor prior to applying for Medicaid.

HEALTH AND WELLNESS WAIVER RESPONSE FORM

Please complete this form to notify the Area Agency on Aging (AAA) of your interest in receiving waiver services on the **Health and Wellness 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) OPTIONS – "YES" or "NO"

YES

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

- ☐ **YES, and I <u>am</u> currently receiving Indiana Medicaid.**
- ☐ **YES, and I <u>have</u> applied for Indiana Medicaid.**
- ☐ **YES, but I have <u>not</u> yet applied for Indiana Medicaid.**

Once we receive your "YES" response, an Options Counselor will contact you to assist you through the required steps for waiver services.

NO

☐ **NO, I am not interested in receiving supports through the Health and Wellness Waiver. Selecting "NO" implies that I fully understand the statements below.**

I understand that if I decline the Health and Wellness Waiver, **<u>I am no longer on any wait list</u>** for the Health and Wellness Waiver.

Once we receive your "NO" response, you will be permanently removed from your current place on the Health and Wellness Waiver wait list.

PLEASE SEND THIS COMPLETED FORM TO:

Options Counselor
Area Agency on Aging
Address
Or FAX to: XXXX

CaMSS Case ID: C-XXX

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 receipt 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 St., 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 Health and Wellness Home and Community-based Services (HCBS) Waiver

If you require more space, include additional pages.

Name of Applicant: _____

Signature of Applicant/Guardian: _____

Date: _____ Reference: CaMss Case 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.