

## Your Appeal Right as an Applicant for HCBS Benefits

If you question the indicated decision, you should discuss this matter with your Case Manager.

### Your Right to Appeal and Have a Fair Hearing:

1) If your application or service is denied, you may file an appeal within 30 days of the decision date shown on this notice. The time limit for filing an appeal is extended by 3 days if this notice is received by mail. Your Home and Community Based Services (HCBS) benefits will continue if you file an appeal within the required time frame of the decision notice. If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the appeal hearing decision.

### How to Request an Appeal:

1) If you wish to appeal this decision, you may request an appeal within 30 days of the date of this notice. The time limit for filing an appeal is extended by 3 days if this notice is received by mail. To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:

MS 04, Hearings and Appeals  
 Indiana Family and Social Services Administration  
 402 W. Washington St.  
 Room E034  
 Indianapolis, IN 46204

If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

2) You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location 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 Case Manager.

3) 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.

### Funding Program: Aged & Disabled Waiver

Mailing date of notice

#### Applicant Identification

Name:	Medicaid #
Address:	County
	Case Manager

#### Cost Comparison Budget (CCB) Identification

CCB Serial Number:	CCB Type:
CCB Start Date:	CCB End Date:

#### Decision Information

	Decision Date
Level of Care	
Reason for Decision	
Signature of FSSA Representative:	Name of FSSA Representative:
IF YOU WISH TO APPEAL THIS DECISION, PLEASE READ THE INFORMATION ABOVE, SIGN AND DATE BELOW, AND RETURN THE HEARINGS & APPEAL COPY OF THIS FORM TO THE ADDRESS GIVEN IN THE INSTRUCTIONS.	

I wish to appeal the above decision, for the following reasons: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature of Applicant/Guardian: \_\_\_\_\_

Date Signed: \_\_\_\_\_