5.00
APPENDIX 3
ADVERSE ACTION NOTICE

The Adverse Action Notice for Home and Community Based Services (HCBS-12) provides the current or potential participant and/or their authorized representative (e.g. guardian or someone with a signed Authorization for Disclosure of Consumer Medical/Health Information that is in effect) with written notification of denials (i.e. of an initial request, request for increase, or additional services), reductions, or closings of services. This notice shall be used for all adverse actions, **except** those due to loss of Medicaid benefits **or** a participant's number on the Independent Living Waiver (ILW) Waiting List as outlined in the Adverse Action policy.

INSTRUCTIONS

The HCBS electronic case record system will generate the adverse action form, which will include the following:

- Participant Information
  - Current or potential participant's name
  - DCN
  - Address
  - Phone number (Include an extension number if appropriate)

NOTE: For current or potential participants with a guardian, ensure the guardian's contact information is included on the form.

- Choose the appropriate "Action Taken" and any applicable "Explanation/Authority" from the Legal References for Adverse Action
  - It may be appropriate to select more than one category from the "Explanation/Authority" section in certain cases.
  - Certain categories for Consumer-Directed Services contain a list of reasons for the adverse action.
- Date of Change
  - The date shall be the day the change will take place
  - This date shall be the eleventh (11th) day from the date the notice is mailed unless noted otherwise as outlined in the Adverse Action policy
- Hearing Request
  - The date in both fields shall be when the participant must request a hearing to continue receiving HCBS at the current level.
  - This date shall be the tenth (10th) day from the date the notice is mailed as outlined in the Adverse Action policy.

- DSDS Staff Information
  - DSDS staff's name
  - Signature
  - Phone number (Including an extension number as appropriate and mailing address)
  - The date the notice is mailed

DISTRIBUTION

Upon completion, the original HCBS-12 shall be mailed to the current or potential participant and/or their authorized representative. A copy is also maintained in the participant's electronic case record.

When a hearing is requested for Medicaid funded services, a copy of the HCBS-12 shall be included in the exhibit packet sent to the Department of Social Services (DSS), Division of Legal Services (DLS).