5.00
APPENDIX 4
APPLICATION FOR STATE HEARING

The Application for State Hearing for Home and Community Based Services allows 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 Form that is in effect) an opportunity to appeal an adverse action taken in regard to denials (i.e., of an initial request of HCBS, request for increase or additional services), reductions, or closings of services.

This application shall be used to confirm a request for an official hearing for all Home and Community Based Services (HCBS) authorized by the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS).

The Application for a State Hearing for HCBS shall be completed by DSDS using information provided by the participant.

NOTE: The Application for a State Hearing for HCBS may be completed by the participant upon request

INSTRUCTIONS

DSDS staff shall enter the following information in the appropriate fields:

- Applicant Information
  - Applicant's Name
  - DCN
  - County
  - Address
  - Phone number (include extension if appropriate)
- Name of applicant requesting the hearing
- Reason for the hearing request
- Authorized Representative Information, when applicable
  - Name
  - Phone number (include extension if appropriate)
  - Address

NOTE: The participant may name anyone as their authorized representative; however, the Authorization for Disclosure of Consumer Medical/Health Information Form shall be completed prior to the release of protected health information (PHI)

- Indicate whether the participant requested to continue receiving services at the current level. If selection is not made, services shall remain authorized

  - This does not apply to participants appealing their number on the Independent Living Waiver (ILW) Waiting List
- Applicant's signature and date, when completed by the participant
  - Indicate in the signature field if the request is made via phone
- Indicate if the hearing request is based on a denial, discontinuance, or reduction
  - This does not apply to participants appealing their number on the ILW Waiting List
- Date the hearing was requested
- Reason for the planned action or decision, including the legal reference for the decision
  - This shall be the same reason and legal reference as stated on the Adverse Action Notice
  - The reason stated on the Waiting List Notice for ILW Services Form regarding the participant's number on the ILW Waiting List, which includes the legal reference
- List service(s) being adversely affected
- DSDS Staff Information
  - Name
  - Phone number (include extension when appropriate)
  - Address
- DSDS staff shall forward the form to their immediate supervisor for review within three (3) business days.
- Division of Legal Services Information (completed by DLS)
  - Date received by DLS
  - Assigned DLS Hearings Officer

SUPERVISOR RESPONSIBILITIES

- Review the request and confirm validity within three (3) business days
- Sign the form
- Submit this form along with the Adverse Action form and the Agency Witness List to the DSDS HCBS Hearings Representative

NOTE: Supervisor may, at their discretion, request additional collateral contacts be made to further verify validity. This additional contact should not exceed three (3) additional business days.

HCBS HEARINGS REPRESENTATIVE RESPONSIBILITIES

- Submit the exhibits packet to the Regional Administrative Hearings Office
- Enter the date sent to DLS
- Send the exhibit packet ten (10) business days prior to the hearing to the Participant, DSDS staff and supervisor

NOTE: The Exhibits packet may be delayed if additional information is required.

DISTRIBUTION

- A copy shall be mailed to the participant and/or their authorized representative, when necessary
- A copy is maintained in the participant's electronic case record