

Dear _____

This letter is to inform you that as a client of the Home and Community Based Services (HCBS) Medicaid Waiver Program, you have a right to appeal any action that affects you in a negative way. This appeal is called a fair hearing. You must be told of the reduction or termination of services ten days before the change happens. This information must be in writing.

As a client, you or an authorized representative may request a hearing within 90 days of the decision to change Medicaid Waiver Services. If you request a fair hearing within 10 days from the notice, your services cannot be changed until the hearing has been held. If your services are not changed while you wait for the fair hearing, and the hearing officer decides you were not entitled to the services, you may have to pay for these services. Your case manager will help you to request a fair hearing.

If you desire to request a fair hearing, you may call or write to:

The Office of Appeal Hearings
1317 Winewood Boulevard
Building 5, Room 205
Tallahassee, Florida 32399-0700
(850) 488-1429

You have the right to attend the fair hearing. You may represent yourself; hire an attorney or have a friend or family member help you. You will be informed of the final decision of the hearing.

Client Signature

Date

Witness