pennsylvania
DEPARTMENT OF HUMAN SERVICES

FAIR HEARING REQUEST
For Infants, Toddlers and Families Waiver

TO: Department of Human Services
Bureau of Hearings & Appeals
P.O. Box 2675
Harrisburg, Pennsylvania, 17105-2675

CC: County MH/ID Program Name: _____
(Specify)

FROM: _____
(Name of Individual/Legal Representative)

_____
(Mailing Address)

_____

_____
(Day Phone) (Fax Number)

I hereby request an opportunity for a fair hearing before the Department of Human Services, Bureau of Hearings and Appeals. I understand that regardless of whether I file this request, my child is entitled to receive services authorized in the IFSP, and that those services will be funded using non-waiver revenues, including Medical Assistance, if my child continues to qualify for Medical Assistance.

NAME OF INFANT OR TODDLER RECEIVING SERVICES:
ACCESS NUMBER OF INFANT OR TODDLER:
I AM APPEALING THE FOLLOWING ACTION:

Please check one of the following items below to indicate the type of hearing you want:

☐ **I want a telephone hearing.**

☐ **I want a face-to-face hearing.**

Please indicate if you need an interpreter or other accommodation, and what type of interpreter or accommodation you need.

☐ **I need an interpreter or the following accommodations:**

_____ _____
(Signature) (Date)

Information About Hearings and Appeals

Families of infants and toddlers with serious disabilities have rights to information, choice and services under the Medicaid Waiver for Infants, Toddlers and Families.

To find out more about the waiver and your rights, please contact your service coordinator.

If you want to file an appeal, please complete the form HS 457 A and refer to the following information:

1. The hearing officer will notify you of the hearing date.
2. You may have a hearing over the telephone or face to face. Please complete this section of the form to express your preference.
3. If you do not have a phone, you can arrange to use a phone of the county MH/ID program or of a friend, relative or neighbor.
4. You will not be granted a hearing if the action being appealed was solely caused by state or federal law regulation or policy, requiring a change in the type of services available to the infant or toddler.
5. At a hearing, you will have the opportunity to testify before the hearing officer and present evidence, and provide a witness to support your appeal.
6. You can represent yourself at a hearing, or have anyone else represent you.
7. You may have an interpreter or other accommodations you need. Be sure to indicate what you need on form HS 457 A.
8. You have the right to a conference with the county MH/ID program to discuss your concerns before filing your appeal and before your appeal is taken if you contact your service coordinator within 10 days of being notified of the decision. If you are dissatisfied with the results of this conference, you retain your right to a fair hearing with the department if you file your appeal within 10 days of your meeting with the county MH/ID program.
9. Your appeal must be filed within 30 days of the decision or action being taken. If you are appealing a decision to reduce, suspend or terminate eligibility or waiver funded services, you must file your appeal within 10 days for waiver funded services or eligibility to continue pending the appeal decision.

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NOTICE OF OPPORTUNITY FOR A FAIR HEARING

Medicaid Waiver for Infants, Toddlers and Families

TO: Family Member

You have the right to a fair hearing and appeal before the Department of Human Services, Bureau of Hearings and Appeals if your child is likely to need the level of care specified in the department's Medicaid Waiver for Infants, Toddlers and Families.

You have the right to a fair hearing and appeal if any of the following has occurred.

1. You have not been given information about the waiver, including information on how to become enrolled.
2. You have not been given the choice to have a determination of your child's level of care.
3. You have not been given the choice to receive waiver funded IFSP services or ICF/ID/ORC.
4. You have been denied waiver funded IFSP services of your choice.
5. You have been denied a waiver funded provider of your choice, or you are a dissatisfied with a decision to refuse, suspend, reduce or terminate IFSP services for your child that are funded under the Medicaid waiver.

If you want to file an appeal, please refer to further instructions on the back of this form and complete and mail the attached form HS 457 A to:

Bureau of Hearings and Appeals
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Telephone: 717-783-3950
Fax Number: 717-772-2769

NOTE: If services are authorized in the child's current IFSP, the family **does not need to appeal** to preserve those services.

REMINDER: Your appeal **must be filed within 30 days of your notification** of the decision or action. If you are appealing a decision to reduce, suspend or terminate eligibility or waiver funded services, you **must file your appeal within 10 days for waiver funded services or eligibility to continue** pending the appeal decision.