



DEPARTMENT OF
HUMAN SERVICES

Notice of Action/Appeals Webinar

Presenters

- Diane Benjamin, PHN, Home Care and Self-Directed Services Policy Staff
- Sarah Schultz, Home Care and Self-Directed Services Policy Staff
- Beth Siewert, MnCHOICES Policy Staff
- Cindee Calton, Home Care and Self-Directed Services Training Staff

Objectives of Today's Webinar

1. Participants will understand why DHS is making these changes.
2. Participants will be able to determine when to use each form.
3. Participants will be able to complete form DHS-2828A.
4. Participants will be able to complete form DHS-2828B.
5. Participants will understand how the appeals process works.

Outline of Today's Webinar

1. Background information
2. When to use each form
3. Notice of Action form DHS-2828A
4. Notice of Action form DHS-2828B
5. The appeals process

Background Information

What is and isn't Being Changed?

Unchanged

You are required to give proper notice

The appeals process

Changed

There are two separate notices for different situations

Because the assessment process is more comprehensive, the notice of action must be broader

Why are the Forms Being Changed?



To meet legal requirements



Benefits to the person



Benefits to you

What are the Benefits to the Person?



Gives the person a clear understanding of any changes



Gives the person a clear understanding of what program(s) they can access and why they may not be able to access other program(s)



Gives the person proper notice



Gives the person clear information about their right to appeal



Gives the person clear information about the appeals process

What are the Benefits to Case Managers and Assessors?



More efficient communication with the person



Allows you to better represent your decision if there is an appeal



Streamlined, easier to fill out forms




Give you a better understanding of the appeals process

When to Use Each Form

When to Use Each Form

Use form 2828A after every assessment and reassessment



m DEPARTMENT OF HUMAN SERVICES
Long-Term Services and Supports
Notice of Action (Assessments and Reassessments)
You are receiving this form because you recently had an assessment or reassessment.

Information You
NAME _____ ADDRESS _____ PHONE NUMBER _____ CITY _____ STATE _____ ZIP CODE _____

Your representative
NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Your lead agency
AGENCY NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Programs and services available to you
After your assessment/reassessment for services, we determined the following programs and services are available to you:

Form 2828A



m DEPARTMENT OF HUMAN SERVICES
Long-Term Services and Supports
Notice of Action (Service Plan)
You are receiving this form to confirm:
1. You receive long-term services and supports provided through Minnesota Department of Human Services programs.
2. You recently requested a decrease or termination in your services or your service plan.
3. You requested a service that has been decreased, terminated and/or denied by the lead agency.

Information You
NAME _____ ADDRESS _____ PHONE NUMBER _____ CITY _____ STATE _____ ZIP CODE _____

Your representative
NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Your lead agency
AGENCY NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Programs and services available to you
We determined that the following programs and services are available to you:

Form 2828B

Use form 2828B after every denial, termination and reduction (DTR) of a service implemented by the case manager throughout the service plan

Examples of When to Use 2828B

- Person requests a change
- Setting change, such as hospitalization
- Change in programs
- Reduction or termination of services
- Change in AC fees

m DEPARTMENT OF HUMAN SERVICES
Long-Term Services and Supports
Notice of Action (Service Plan)

You are receiving this form to confirm:
1. You receive long-term services and supports provided through Minnesota Department of Human Services programs.
2. You recently requested a decrease or termination in your services or your service plan.
3. You requested a service that has been decreased, terminated and/or denied by the lead agency.

Information You

Name _____
ADDRESS _____

Your representative

Name _____ CITY _____ STATE _____ ZIP CODE _____
ADDRESS _____

Your lead agency

AGENCY NAME _____ CITY _____ STATE _____ ZIP CODE _____
ADDRESS _____ AGENCY REPRESENTATIVE _____ PHONE NUMBER _____
FAX _____

Programs and services available to you
We determined that the following programs and services are available to you:

Form 2828B

Notice of Action Form DHS-2828A

DHS-2828A: Benefits



Starts with programs that are available to the person



Is dynamic for easier use



Drop-down menu of legal citations for easier use



Appeals Division contact information and appellant rights included

mn DEPARTMENT OF HUMAN SERVICES
Long-Term Services and Supports
Notice of Action (Assessments and Reassessments)
You are receiving this form because you recently had an assessment or reassessment.

Information You
NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ PHONE NUMBER _____ DATE _____

Your representative
NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ PHONE NUMBER _____

Your lead agency
AGENCY NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ PHONE NUMBER _____

Programs and services available to you
After your assessment/reassessment for services, we determined the following programs and services are available to you.

Page 1 of 8

DHS-2828A: Who?

County or tribe
staff completes
following
assessment or
reassessment

m DEPARTMENT OF HUMAN SERVICES
Keep Them Strong and Support
Notice of Action (Assessments and Reassessments)

You are receiving this form because you recently had an assessment or reassessment.

Information

You

Your representative

Your lead agency

Programs and services available to you

Sends to:
person, authorized
representative, case
manager/care
coordinator (if
applicable)

Contact the dsd.rrs@state.mn.us via encrypted email for technical assistance on completing this form.

DHS 2828A: When?



Changes in NF level of care: at least 30 but no more than 60 days before the change takes effect



All other changes or notifications: at least 10 days before the any changes takes effect

Completing 2828A: Overview

Link to CBSM instructions



Person's information



Your information



Dynamic check boxes



Clear Form

mi DEPARTMENT OF HUMAN SERVICES
Long-Term Services and Supports
Notice of Action (Assessments and Reassessments)

IMPORTANT: If you are not able to complete this form online, click Print Blank Form to print the form and complete it by hand.

Print Blank Form

LEAD AGENCIES: For more information on this process and instructions to complete this form, see [CBSM - Notice of action](#).

You are receiving this form because you recently had an assessment or reassessment. DATE

Information

You

NAME	FBI	PHONE NUMBER
ADDRESS	CITY	STATE ZIP CODE

Your representative

NAME	PHONE NUMBER
ADDRESS	CITY STATE ZIP CODE

Your lead agency

AGENCY NAME	AGENCY REPRESENTATIVE	PHONE NUMBER
ADDRESS	CITY	STATE ZIP CODE

Programs and services available to you

After your assessment/reassessment for services, we determined the following programs and services are available to you.

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Notice of action about denial, termination or reduction of services

After your assessment/reassessment for services, we determined that following programs and services are either not available to you or will be changed. This is the action being taken.

No change to your current programs or services
 Reduction in services or budget
 Termination
 Denial of services

Page 1 of 4



Date the form was sent



Representative's information



Narrative description of available program

Note: the effective date(s) of the change(s) is at the end of each category (DTR).

Completing 2828A: Programs and Services Available to You

Programs and services available to you

After your assessment/reassessment for services, we determined the following programs and services are available to you.

Initial assessment: You completed a MnCHOICES assessment on 9/21/17. Your assessment showed eligibility for nursing facility level of care and you have needs that may be met by waiver services. You are under 65 years old, so you are eligible for supports and services available under the Community Access for Disability Inclusion (CADI) waiver for persons under the age of 65.

Programs and services available to you

After your assessment/reassessment for services, we determined the following programs and services are available to you.

Reassessment: You completed an assessment on 9/21/17. You continue to be eligible for nursing facility level of care and you continue to have needs that can be met with waiver services. The CADI waiver continues to be an option to access long term supports and services.

Completing 2828A: Dynamic Check Boxes

Check Form

mn DEPARTMENT OF HUMAN SERVICES
Long-Term Services and Supports
Notice of Action (Assessments and Reassessments)

IMPORTANT: If you are not able to complete this form online, click Print Blank Form to print the form and complete it by hand.

[Print Blank Form](#)

LEAD AGENCIES: For more information on this process and instructions to complete this form, see [CSM - Notice of Action](#).

You are receiving this form because you recently had an assessment or reassessment. DATE: _____

Information

You

NAME: _____ PHONE NUMBER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

Your representative

NAME: _____ PHONE NUMBER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

Your lead agency

AGENCY NAME: _____ AGENCY REPRESENTATIVE: _____ PHONE NUMBER: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

Programs and services available to you

After your assessment/reassessment for services, we determined that the following programs and services are available to you.

Notice of action about denial, termination or reduction of services

After your assessment/reassessment for services, we determined that following programs and services are either not available to you or will be changed. This is the action being taken.

No change to your current programs or services
 Reduction in services or budget
 Termination
 Denial of services

Page 1 of 4

Notice of action about denial, termination or reduction of services

After your assessment/reassessment for services, we determined that following programs and services are either not available to you or will be changed. This is the action being taken.

No change to your current programs or services
 Reduction in services or budget
 Termination
 Denial of services

Reduction in services or budget

Program/service

We reduced your level of participation in the following program(s) or services:

Alternative Care (AC)
 Brain Injury (BI) Waiver
 Community Access for Disability Inclusion (CADi) Waiver
 Community Alternative Care (CAC) Waiver
 Developmental Disabilities (DD) Waiver
 Elderly Waiver (EW)
 Personal care assistance (PCA).

Reason

The reason for this reduction is because:

There was a change in your assessed needs.
 You chose to change your amount of service.
 You chose to use an alternative service.

Legal citation

The following Minnesota statute applies to this change:

Explanation

This is the reason why this reduction happened. It includes information about how your plan for supports or your access to resources is affected.

Checking a box will create additional fields that correspond to that box

Completing 2828A: Denial of Services

Notice of action about denial, termination or reduction of services

After your assessment/reassessment for services, we determined that following programs and services are either not available to you or will be changed. This is the action being taken.

- No change to your current programs or services**
- Reduction in services or budget**
- Termination**
- Denial of services**

Denial of services should always be checked on an form DHS-2828A. There will always be some programs a person is not eligible for.

Completing 2828A: Denial of Services, Continued

Denial of services

Program/service

You have been denied for the following program(s) or services:

- Alternative Care (AC)
- Elderly Waiver (EW)
- Essential Community Supports (ECS)
- Personal care assistance (PCA)
- Developmental Disabilities (DD) Waiver
- Brain Injury (BI) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Community Alternative Care (CAC) Waiver.

Select all programs the person is not eligible for.

Completing 2828A: Denial of Services Dynamic Check Boxes

Denial of services

Program/service

You have been denied for the following program(s) or services:

Alternative Care (AC)

Reason

You were denied because:

- You are not 65 years or older
- You do not meet financial eligibility criteria
- You do not meet other eligibility criteria
- You do not need the level of care that a nursing facility provides
- Your needs are met without an AC-paid service
- You chose not to use the AC program.

Legal citation

Minnesota Statute, Section 256B.0913 applies to this change (Alternative Care [AC] Program)

For each program, a list of possible reasons expands when the program is selected

For your convenience, the legal citation is automatically added for you.

Completing 2828A: Denial Explanation Example

Denial explanation

This is the reason why this service or program was denied. It includes information about how your plan for supports or your access to resources is affected.

You do not meet either the level of care thresholds for the reasons indicated above for the following programs: CAC, DD, BI. You do not meet the age requirements to access the following programs: EW, AC, ECS. You plan to utilize the CADI waiver supports, informal caregiver supports, and personal care assistance services to meet your needs.



Be sure to enter an effective date

Completing 2828A: Selecting Legal Citations

Reduction in services or budget

Program/service
We reduced your level of participation in the following program(s) or services:

- Alternative Care (AC)
- Brain Injury (BI) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Community Alternative Care (CAC) Waiver
- Developmental Disabilities (DD) Waiver
- Elderly Waiver (EW)
- Personal care assistance (PCA)

Reason
The reason for this reduction is because:

- There was a change in your assessed needs
- You chose to change your amount of service
- You chose to use an alternative service.

Legal citation
The following Minnesota statute applies to this change:

Explanation
This is the reason why this reduction happened. It includes information about how your plan for supports or your access to resources is affected.

Legal citation

The following Minnesota statute applies to this change:



For reductions and termination: for your convenience, there is a drop down menu of applicable legal citations to select from.

Legal citation

The following Minnesota statute applies to this change:

- Alternative Care (AC) Program – Minn. Stat. §256B.0913
- Developmental Disabilities (DD) Waiver – Minn. Stat. §256B.092
- Disability waivers: Brain Injury (BI), Community Alternative Care (CAC) and Community Access for Disability Inclusion (CADI) – Minn. Stat. §256B.49
- Elderly Waiver (EW) Program – Minn. Stat. §256B.0915
- Federal waiver plan
- Personal care assistance (PCA) services – Minn. Stat. §256B.0659

Completing 2828A: Termination Explanation Example

Explanation

This is the reason why this service or program is ending. It includes information about how your plan for supports or your access to resources is affected.

You were on the Consumer Support Grant (CSG). Your condition has changed and your needs can no longer be met by CSG. Your needs may be met by services and supports available through the CADI waiver. You can refer to your worksheet provided by your assessor (6791A) for the any next steps that you need to take.



Be sure to coordinate the effective date with the person's transition to the waiver

Completing 2828A: Reduction Explanation Example

Explanation

This is the reason why this reduction happened. It includes information about how your plan for supports or your access to resources is affected.

Your condition has improved over the past year. You have gained strength and you are now able to eat independently. Additionally, you purchased the recommended adapted equipment through the CADI waiver to increase your ability to feed yourself more independently. You no longer have a PCA dependency for eating.

You were previously eligible for 4 hours of PCA per day, your current assessment reduces PCA time to 3 hours per day.



Be sure to enter an effective date, if applicable

DHS 2828A: Persons Receiving PCA on a Waiver

This form is titled "Notice of Action (Assessments and Reassessments)" and is issued by the Michigan Department of Human Services. It includes sections for "Information" (with fields for name, address, and phone), "Your representative" (with fields for name, address, and phone), and "Your lead agency" (with fields for name, address, and phone). A large section at the bottom is titled "Programs and services available to you" and contains a table with columns for "Program/Service", "Date", "Status", and "Notes".

DHS-2828A

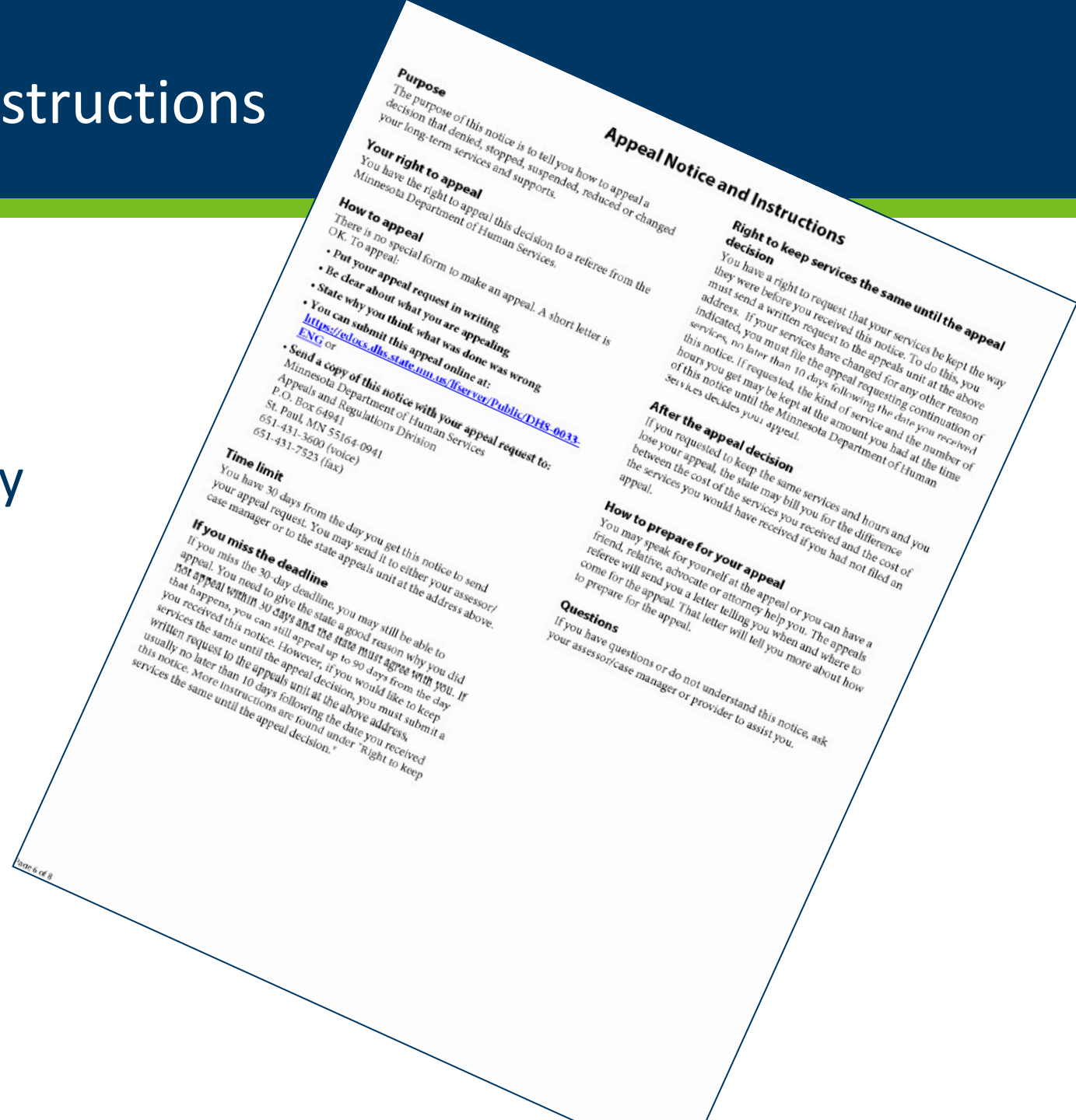
Send form DHS-2828A with assessment results and indicate that form DHS-2828B will include the effective date

This form is titled "Notice of Action (Service Plan)" and is issued by the Michigan Department of Human Services. It includes sections for "Information" (with fields for name, address, and phone), "Your representative" (with fields for name, address, and phone), and "Your lead agency" (with fields for name, address, and phone). A large section at the bottom is titled "Programs and services available to you" and contains a table with columns for "Program/Service", "Date", "Status", and "Notes".

DHS-2828B

2828A Appeal Notice and Instructions

- Information for the person on filing an appeal
- No editing needs to be done by the county/tribe



Notice of Action Form DHS-2828B

DHS-2828B: Benefits



Starts with programs that are available to the person



Is dynamic for easier use



Drop-down menu of legal citations for easier use



Appeals Division contact information and appellant rights included

m1 DEPARTMENT OF HUMAN SERVICES
Long-Term Services and Supports
Notice of Action (Service Plan)

You are receiving this form to confirm:
1. You receive long-term services and supports programs.
2. You recently requested a decrease or termination in your services or your service plan.
3. You requested a service that has been decreased, terminated and/or denied by the lead agency.

Information

You
NAME _____
ADDRESS _____

Your representative
NAME _____ CITY _____ PHONE NUMBER _____
ADDRESS _____ STATE _____ ZIP CODE _____

Your lead agency
AGENCY NAME _____ CITY _____ PHONE NUMBER _____
ADDRESS _____ STATE _____ ZIP CODE _____
AGENCY REPRESENTATIVE _____

Programs and services available to you
We determined that the following programs and services are available to you:

PRINT 1 of 7

DHS-2828B: Who?

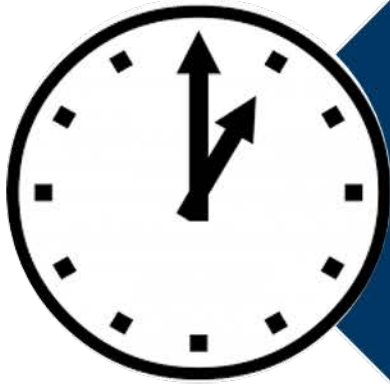
Case
Manager/planner
completes
following change
in services

The image shows a tilted document titled "Notice of Action (Service Plan)" from the Minnesota Department of Human Services. The form includes a header with the state logo and name, followed by a title and a barcode. Below the title, there are instructions and a list of reasons for the notice of action. The form is divided into several sections: "Information" with fields for name, address, and phone; "Your representative" with fields for name, title, and phone; "Your lead agency" with fields for name, address, and phone; and "Programs and services available to you" with a table for listing services. The form is tilted and overlaid on a large grey arrow pointing from left to right.

Sends to:
person, authorized
representative, care
coordinator (if
applicable)

Contact the dsd.rrs@state.mn.us via encrypted email for technical assistance on completing this form.

DHS 2828B: When?



At least 10 days before a denial, termination or reduction of services the person is receiving throughout the service plan year



At least 10 days before a change in Alternative Care (AC) fees

Completing 2828B: Overview

Link to CBSM instructions



Person's information



Your information



Dynamic check boxes



Clear Form

m DEPARTMENT OF HUMAN SERVICES
LONG-TERM SERVICES AND SUPPORTS
Notice of Action (Service Plan)

IMPORTANT: If you are not able to complete this form online, click Print Blank Form to print the form and complete it by hand.

[Print Blank Form](#)

LEAD AGENCIES: For more information on this process and instructions to complete this form, see [CBSM - Notice of action](#).

You receive long-term services and supports provided through Minnesota Department of Human Services programs. You are receiving this form to confirm either:

1. You recently requested a decrease or termination in your services or your service plan, or
2. You requested a service that has been decreased, terminated and/or denied by the lead agency.

DATE

Information

You

NAME	PIB	PHONE NUMBER
ADDRESS	CITY	STATE ZP CODE

Your representative

NAME	PHONE NUMBER
ADDRESS	CITY STATE ZP CODE

Your lead agency

AGENCY NAME	AGENCY REPRESENTATIVE	PHONE NUMBER
ADDRESS	CITY	STATE ZP CODE

Programs and services available to you

We determined that the following programs and services are available to you:

Notice of action about denial, termination or reduction of services

We determined that following programs and services are either not available to you or will be changed. This is the action being taken:

Reduction
 Termination

Page 1 of 5



Date the form was sent



Representative's information



Narrative description of available program

Note: the effective date(s) of the change(s) is also required and is at the end of each category (DTR).

Completing 2828B: Programs and Services Available to You

Programs and services available to you

We determined that the following programs and services are available to you:

PCA services, homemaking, Lifeline, skilled nurse visit, Adult Day program

Completing 2828B: Dynamic Check Boxes

Clear Form

m DEPARTMENT OF HUMAN SERVICES
LONG-TERM SERVICES AND SUPPORTS
Notice of Action (Service Plan)

IMPORTANT: If you are not able to complete this form online, click Print Blank Form to print the form and complete it by hand.

[Print Blank Form](#)

LEAD AGENCIES: For more information on this process and instructions to complete this form, see [2828B - Notice of Action](#).

You receive long-term services and supports provided through Minnesota Department of Human Services programs. You are receiving this form to confirm either:

1. You recently requested a decrease or termination in your services or your service plan, or
2. You requested a service that has been decreased, terminated and/or denied by the lead agency.

Information

You

NAME: _____ FMR: _____ PHONE: _____
ADDRESS: _____ CITY: _____ STATE: _____

Your representative

NAME: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

Your lead agency

AGENCY NAME: _____ ADDRESS: _____ PHONE NUMBER: _____
ADDRESS: _____ STATE: _____ ZIP CODE: _____

Programs and services available to you

We determined that the following programs and services are available to you:

Notice of action about denial, termination or reduction of services

We determined that following programs and services are either not available to you or will be changed. This is the action being taken:

Reduction
 Termination

Page 1 of 3

Notice of action about reduction or denial of services

We determined that following programs and services are either not available to you or will be changed. This is the action being taken:

- Reduction
- Termination
- Denial

Reduction

We are reducing one or more programs and/or services:

- Alternative Care (AC)
- Essential Community Supports (ECS)
- Elderly Waiver (EW)
- Developmental Disabilities (DD) Waiver
- Community Alternative Care (CAC) Waiver
- Community Access for Disability Inclusion (CADi) Waiver
- Consumer Support Grant (CSG)
- Brain Injury (BI) Waiver
- Personal care assistance (PCA)
- Semi-independent living services (SILS)
- Other

Reason

The reason for this reduction is because:

- There was a change in your assessed needs
- You chose to change your amount of service
- You chose to use an alternative service.

Legal citation

The following Minnesota statute applies to this change:

[Add legal citation](#)

Explanation

This is the reason why this reduction happened. It includes information about how your plan for supports or your access to resources is affected.

Checking a box will create additional fields that correspond to that box

Completing 2828B: Reduction of Services Example

Authorized through

Legal citation menu

We reduced your level of participation in the following programs and/or services:

PCA services were reduced from 4 hours per day to 3 hours per day.

- Alternative Care (AC)
- Essential Community Supports (ECS)
- Elderly Waiver (EW)
- Developmental Disabilities (DD) Waiver
- Community Alternative Care (CAC) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Consumer Support Grant (CSG)
- Brain Injury (BI) Waiver
- Personal care assistance (PCA)
- Semi-independent living services (SILS)
- Other.

Reason
The reason this service or program is ending is because:

- There was a change in your assessed needs
- You chose to change your amount of service
- You chose to to use an alternative service.

Legal citation
The following Minnesota statute applies to this change:

- Personal care assistance (PCA) services – Minn. Stat. §256B.0659
- Disability waivers: Brain Injury (BI), Community Alternative Care (CAC) and Community Access for Disability Inclusion (CADI) – Minn. Stat. §256B.49

[Add legal citation](#)

Explanation
This is the reason why this reduction happened. It includes information about how your plan for supports or your access to resources is affected.

Your upper body strength has improved and you purchased adaptive equipment to assist with eating; you no longer have a PCA dependency in eating. Last year, you used some of your PCA time for homemaking related to your activities of daily living. Homemaking services will be added to your plan (5 hours per week) to continue to support you with cleaning and shopping for food and your other household needs.

What is being reduced

Select a reason from the given choices

Give a narrative explanation of the change

Completing 2828B: Reduction Explanation Example

We reduced your level of participation in the following programs and/or services:

PCA services were reduced from 4 hours per day to 3 hours per day.

Explanation

This is the reason why this reduction happened. It includes information about how your plan for supports or your access to resources is affected.

Your upper body strength has improved and you purchased adaptive equipment to assist with eating; you no longer have a PCA dependency in eating. Last year, you used some of your PCA time for homemaking related to your activities of daily living. Homemaking services will be added to your plan (5 hours per week) to continue to support you with cleaning and shopping for food and your other household needs.



Be sure to enter an effective date

Completing 2828B: Termination Explanation Example

We are ending one or more programs and/or services:

You told your case manager that you would like to discontinue home delivered meals, 3 meals per week.

Explanation

This is the reason why this service or program is ending. It includes information about how your plan for supports or your access to resources is affected.

You said you didn't really like the home delivered meals. Your upper body strength has improved after your shoulder surgery and your physical therapy. As a result, you said that you would like to try cooking some simple meals yourself or with support from your informal caregiver, as needed. You also go to Adult Day 2 days per week and you said that you like the meals they serve.



Be sure to enter an effective date

Completing 2828B: Denial Explanation Example

We are denying one or more programs and/or services:

You requested a lightweight wheelchair.

Denial explanation

The reason why this service or program is denied. It includes information about how your plan for supports or your access to resources is affected.

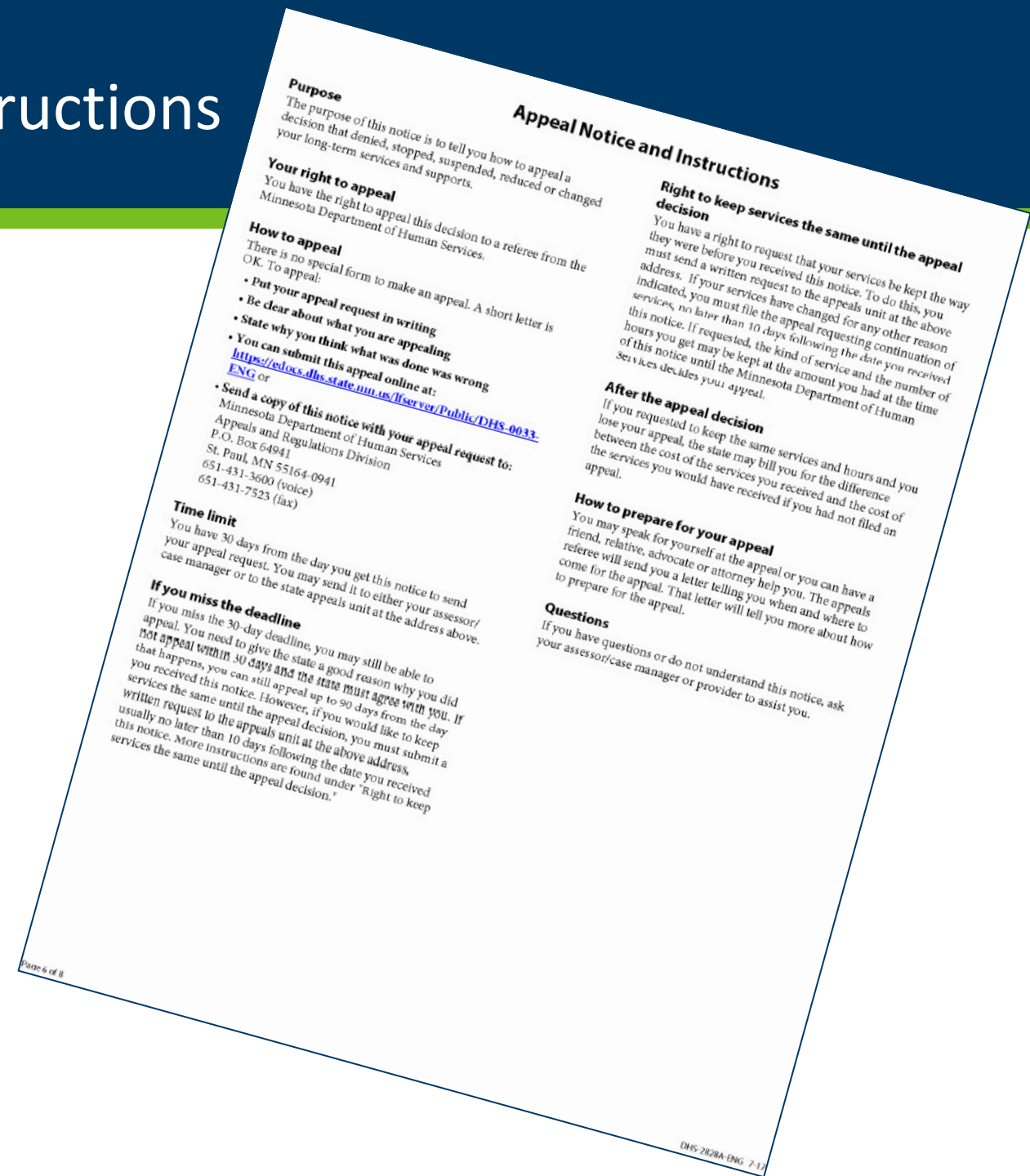
You requested a lightweight wheelchair to use when you are having trouble walking long distances while getting out into the community. A wheelchair would also help your caregiver support you. You need to contact a medical supply company to see if your medical assistance will purchase the wheelchair prior to using CADI waiver funds.



Be sure to enter an effective date

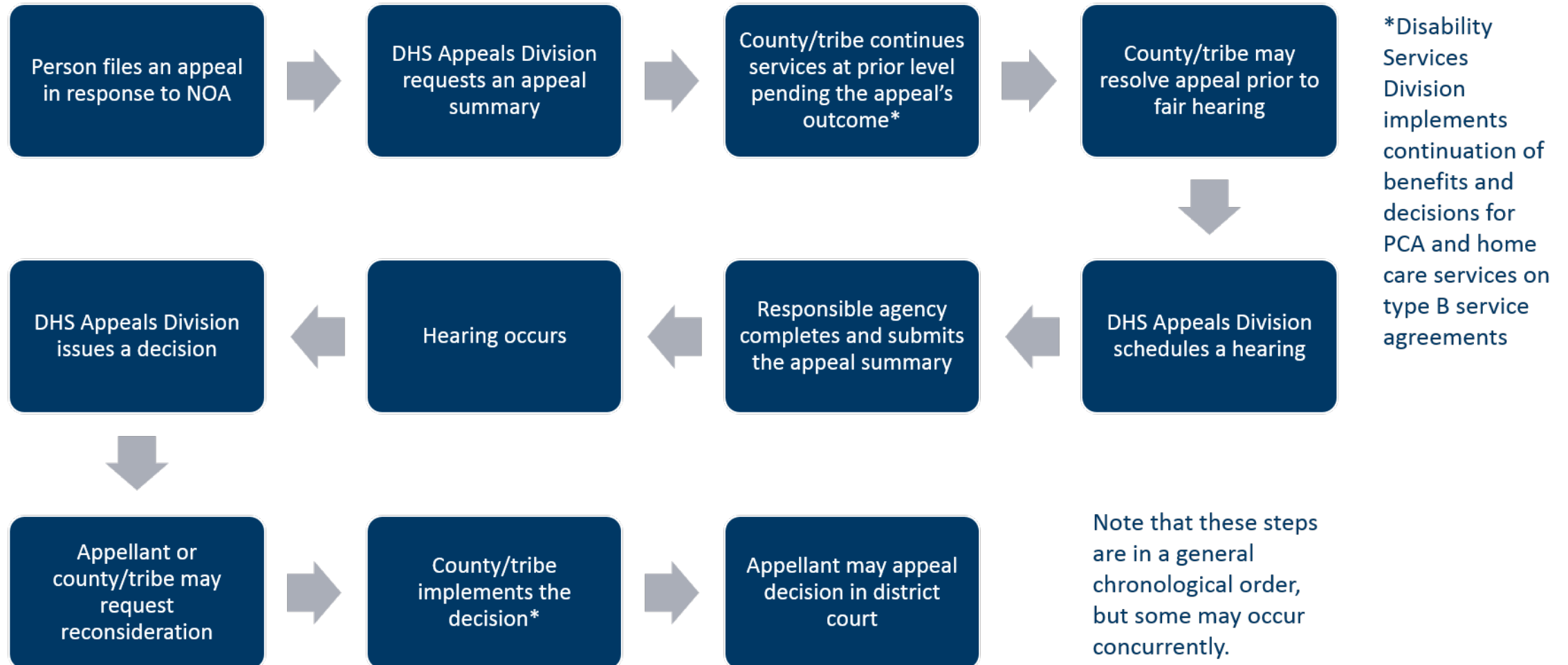
2020B Appeal Notice and Instructions

- Information for the person on filing an appeal
- No editing needs to be done by the county/tribe

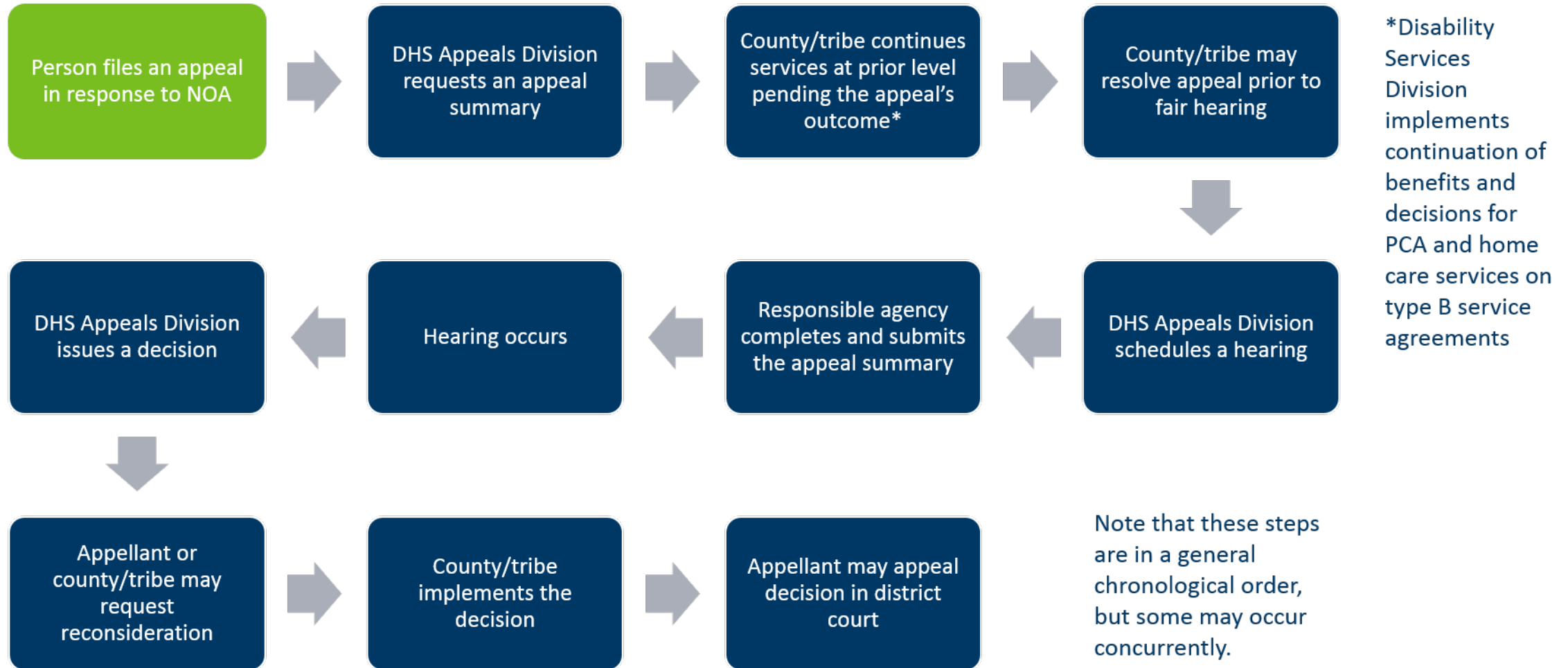


Appeals Process

Appeals Process Overview



Appeals Process Overview: Filing



Person Files an Appeal

Written Request



County, tribe or DHS Appeals Division



Within 30 calendar days of receiving the notice



Within 90 days with good reason for the delay

Purpose
The purpose of this notice is to tell you how to appeal a decision that...

Appeal Notice and Instructions

Minnesota Department of Human Services

Client information:

NAME OF AGENCY
NAME OF PROGRAM(S)
NAME
STREET ADDRESS
CITY
STATE
ZIP CODE
CASE NUMBER
TELEPHONE NUMBER

Do you need an interpreter for the hearing?
 Yes No

Attorney/Advocate information:

ATTORNEY OR ADVOCATE'S NAME
STREET ADDRESS
CITY
STATE
ZIP CODE
TELEPHONE NUMBER
If yes, what is your preferred language?

Reason for appeal:

I disagree with the agency/state action in my case. I want to appeal to the state. I am appealing because:

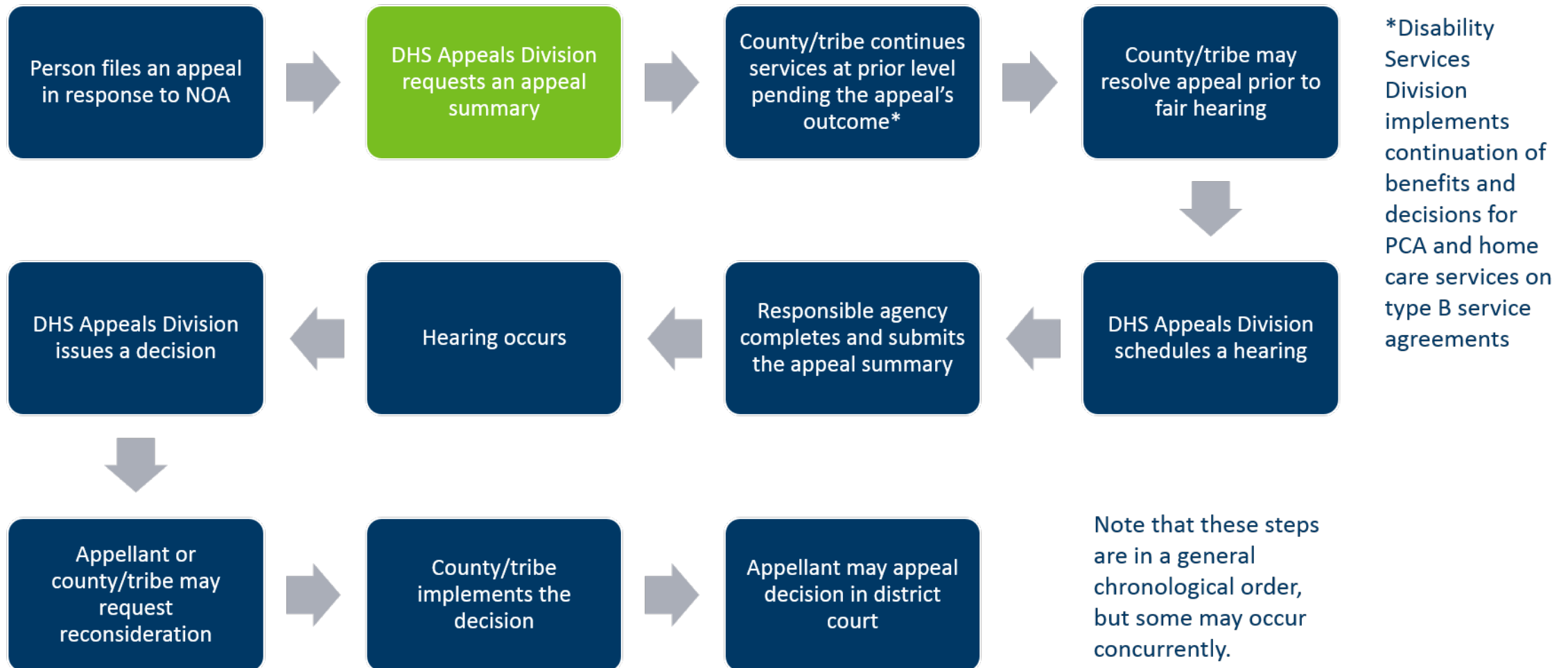
Status of benefits:

Check one of the boxes below if the benefits you get now are being cut or stopped:
 I want to keep getting benefits until the appeal decision.
 I want to stop getting benefits until the appeal decision.
If you file an appeal within 10 days of the agency action, your benefits may continue if you do not check one of the boxes.

Signature:
CLIENT SIGNATURE
DATE

Note: If you need help completing this form, or want to discuss your appeal with someone, you may contact a private attorney or the legal services office that serves your agency.

Appeals Process Overview: Summary Request



Appeal Summary

DHS Appeals
Division



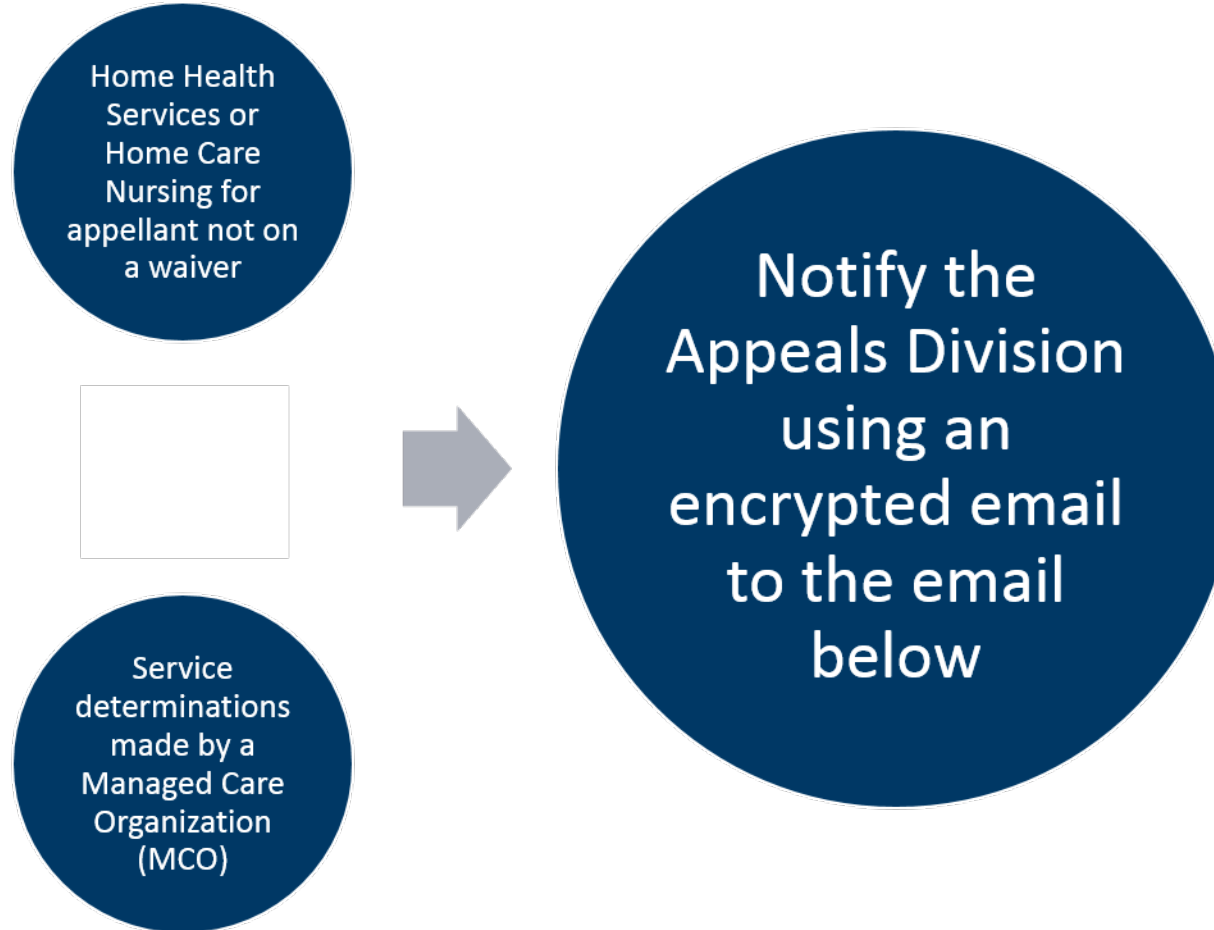
Requests summary
from entity whose
decision is being
appealed

A Reminder About Encrypted Emails



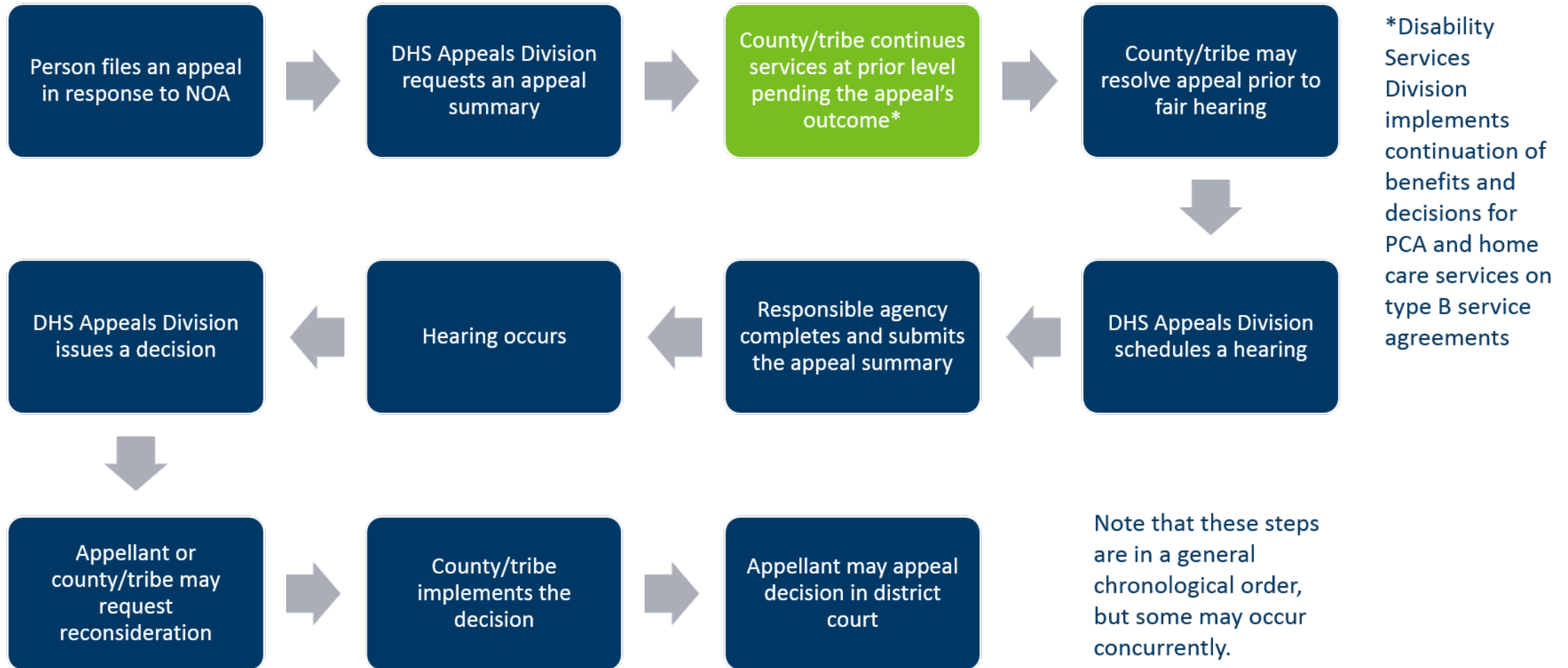
When sending
protected
information via email,
it is important to
remember to encrypt
it

If the County/Tribe Receives the Request in Error



DHS.Appeals.Modifications@state.mn.us

Appeals Process Overview: Continuation



Continuation of Services

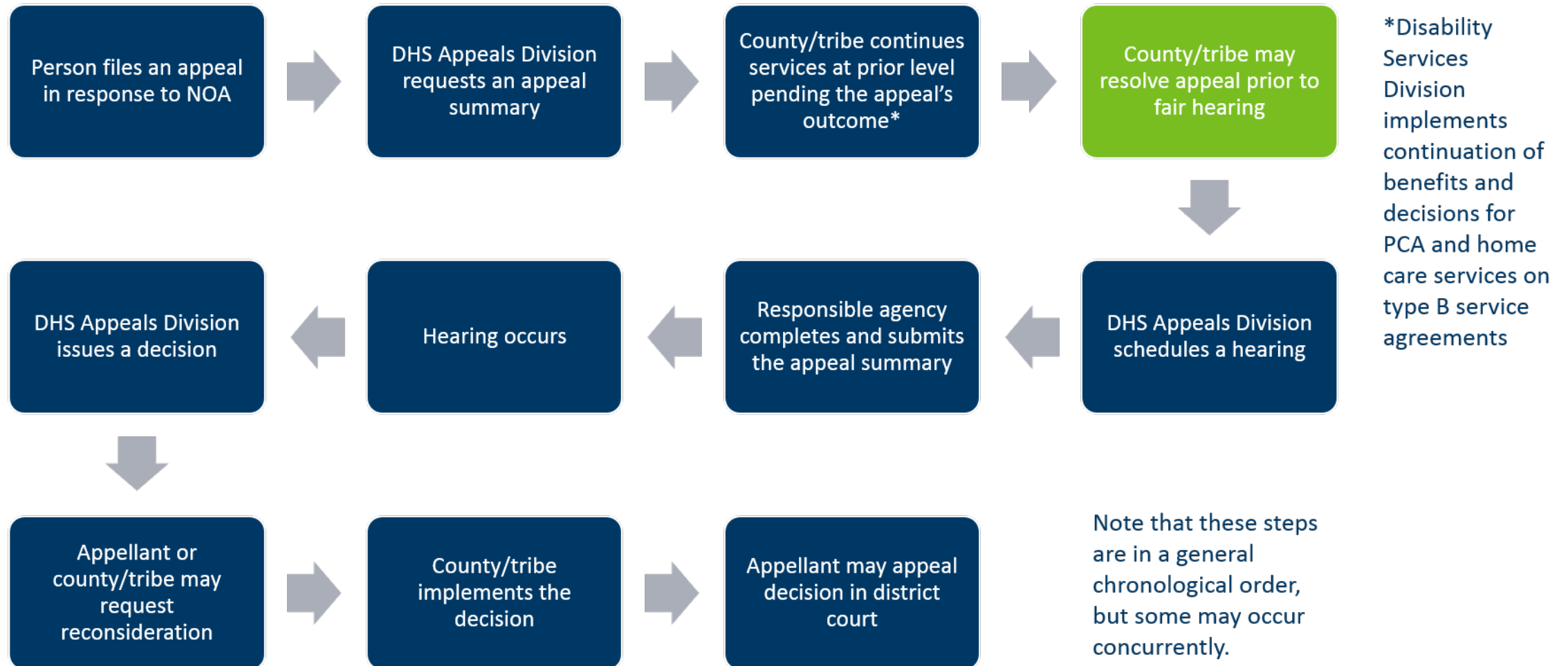
If a person is not on a waiver, PCA and Home Care services

- DHS continues services
- No action needed from county/tribe

All other services

- County/tribe continues services

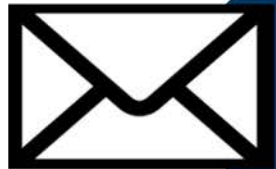
Appeals Process Overview: Resolving



County/Tribe and Person Resolve on Their Own



The county/tribe and the person may resolve the dispute with additional communication

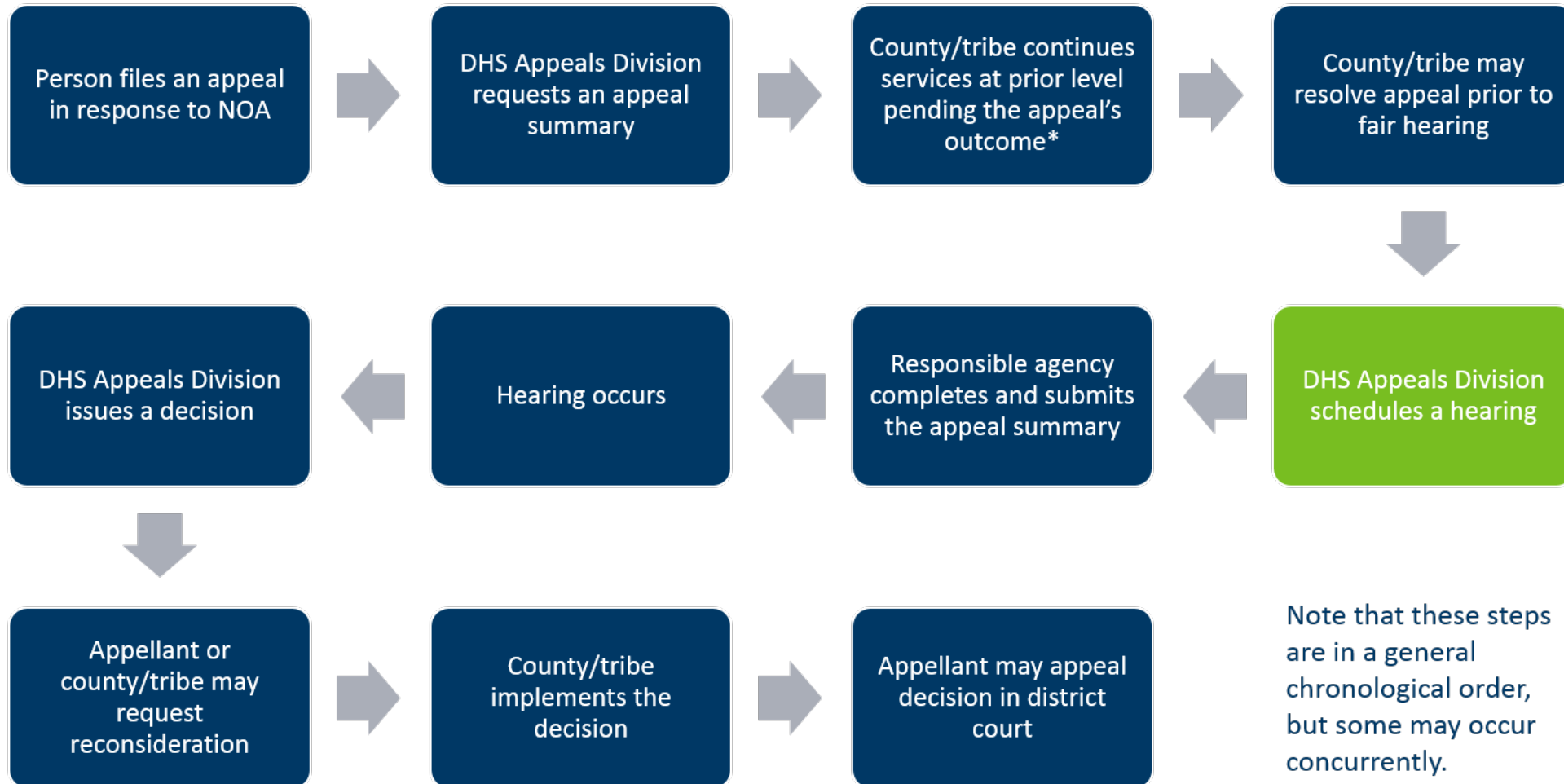


The appellant contacts the DHS Appeals Division



Unless otherwise directed by the judge, the county/tribe still completes an appeals summary notifying the judge of the resolution

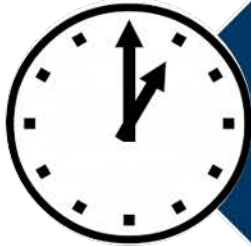
Appeals Process Overview: Scheduling



*Disability Services Division implements continuation of benefits and decisions for PCA and home care services on type B service agreements

Note that these steps are in a general chronological order, but some may occur concurrently.

Scheduling the Hearing



DHS Appeals Division will schedule a hearing that permits easy access for the person

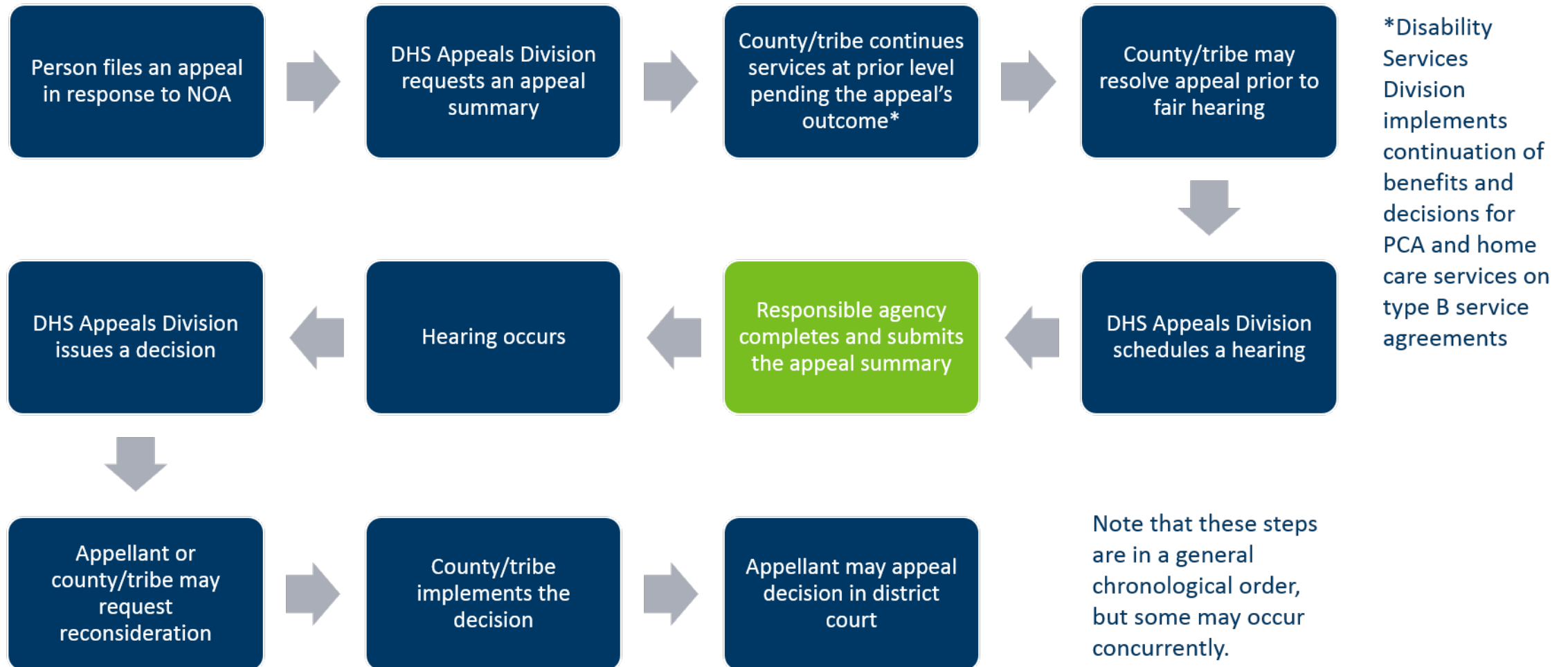


DHS Appeals Division will notify the county/tribe and the appellant of the hearing date, time and location




Counties and tribes can expect the notice of hearing within 30 business days of receiving the request

Appeals Process Overview: Appeals Summary



County/Tribe Completes Summary

 Minnesota Department of Human Services
State Agency Appeals Summary

5-14
DHS-01559-10

CLIENT'S NAME _____ PHONE NUMBER _____
STREET ADDRESS _____ APT NUMBER _____
CITY _____ STATE _____ ZIP CODE _____

Does client have a representative or advocate? Yes No If yes, complete:
REPRESENTATIVE/ADVOCATE NAME _____ CITY _____ PHONE NUMBER _____
STREET ADDRESS _____ STATE _____ ZIP CODE _____

Does appellant need an interpreter for the hearing? Yes No
If yes, what is his/her preferred language? _____

Program(s): (check all applicable programs)
 MFIP GA
 MFIP-EA GAMC
 EGA MA-Prepaid
 Food Support MA-Prior Auth.
 Other _____ MA-SMRT
 MinnesotaCare
 MSA
 SS-Dev. Disability
 SS-Other

Action taken: (check all applicable actions)
 Denial Suspension Developmental disability conciliation
 Reduction Overpayment Other _____
 Termination Corrective payment

Date of Notice of Action _____
Date county received appeal request _____

Authority for action: Cite applicable federal regulation, state statute, rule or program manual section relied upon.

Appeal issues: Briefly summarize the facts and the reason the agency made its decision. If appeal is brought by a person with a developmental disability subject to a conciliation conference, omit this summary and attach conciliation conference report instead.

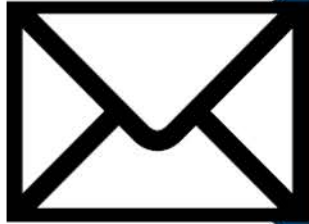
Are benefits/services continuing? Yes No
Should this be a telephone hearing? Yes No

Attach copies of:
• Notice of Action/Grant Calculation (if applicable)
• Client's Request for Appeal
• Developmental Disability Conciliation Conference Report (if applicable)
• Relevant statutory, rule, or manual provisions
• Other relevant documents (identify)

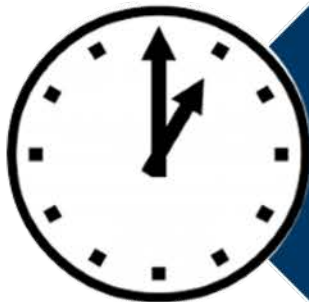
AGENCY REPRESENTATIVE (Type or print name) _____ PHONE NUMBER _____
TITLE _____ DATE _____

Original - State agency
Copy - County Agency
Copy - Client

County/Tribe Submits Summary



The appellant, Appeals Division
and Aging and Disability Services



At least three days before the
hearing

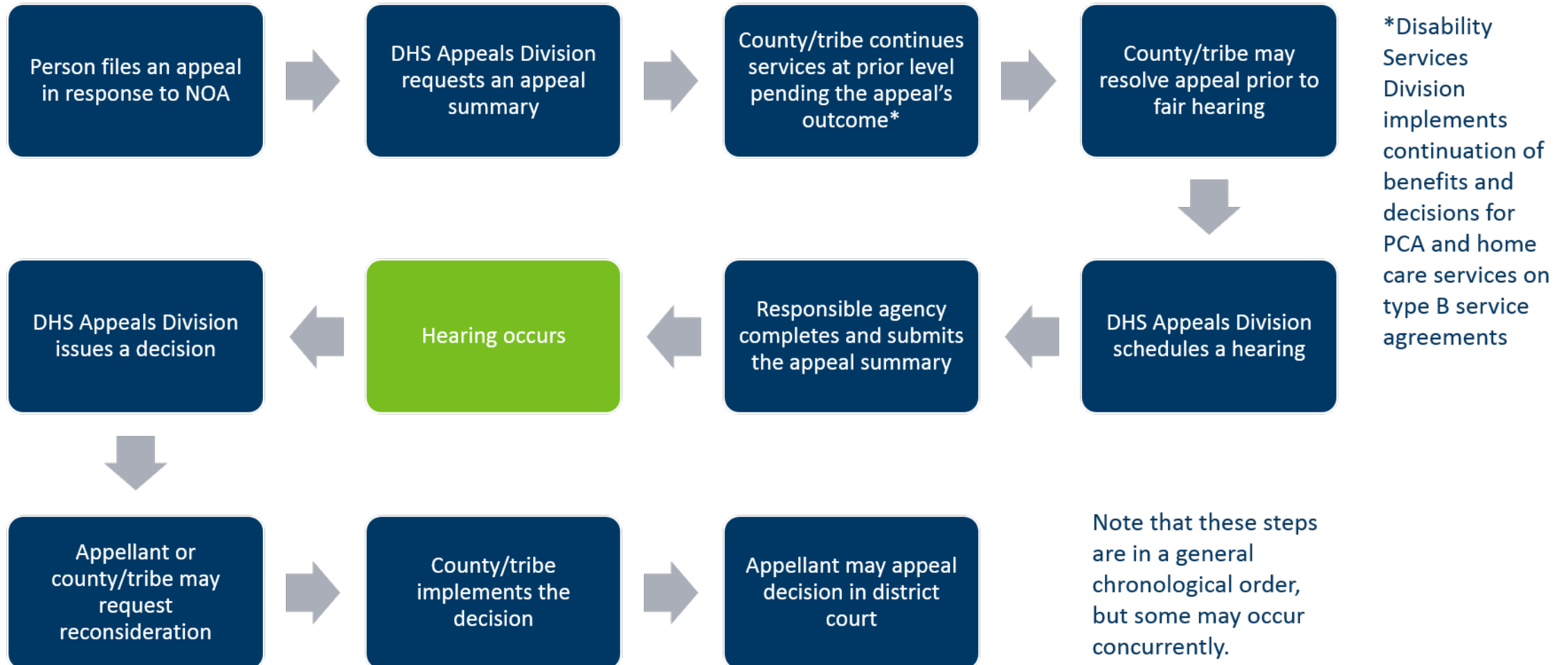
DHS Appeals Division via encrypted email:

DHS.appealsummary@state.mn.us




DHS Aging and Disability Services via encrypted email:

DHS.CCAappeals@state.mn.us




Appeals Process Overview: Hearing



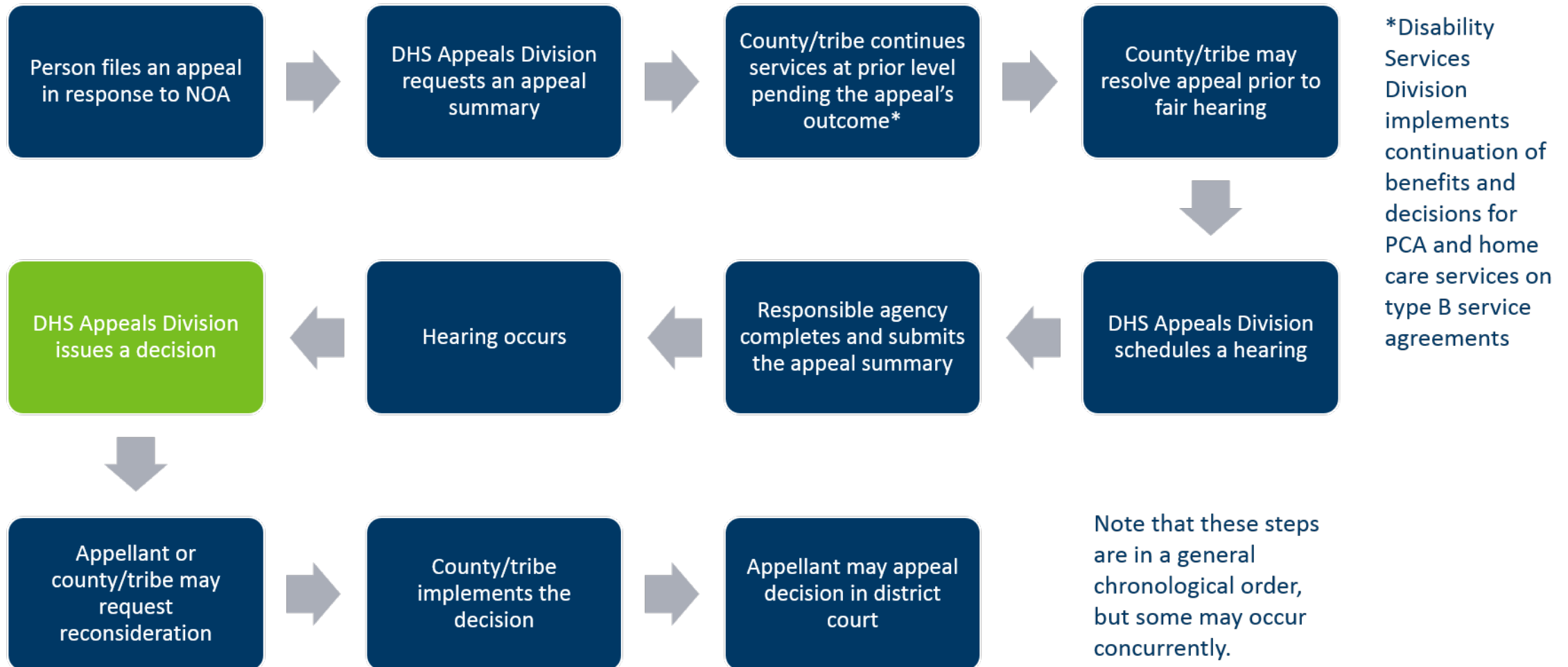
The Hearing: What to Expect

-  Semi-formal process
-  All participants are sworn in
-  The human services judge will direct the participants when to respond

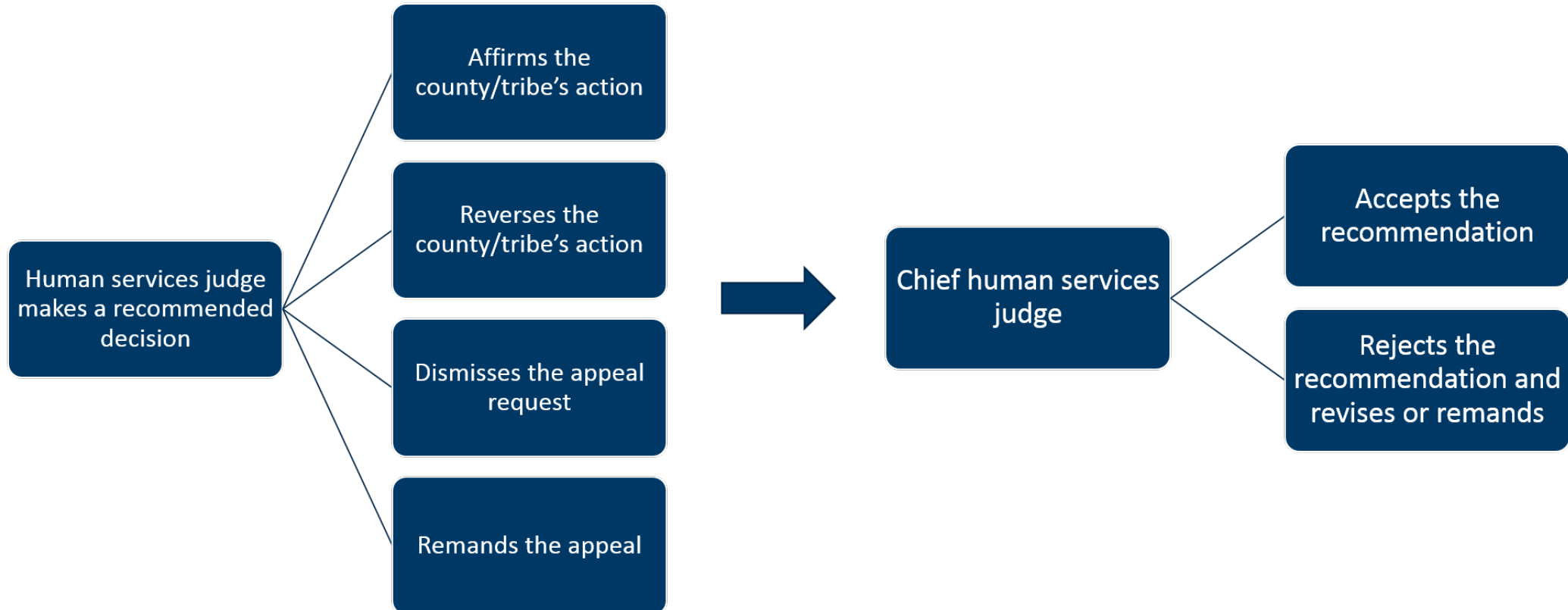
The Hearing: The DHS Appeals Division Might . . .

-  Record the hearing
-  Keep the hearing record open
-  Prepare a transcript (if the appellant appeals the decision in district court)

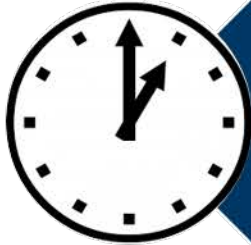
Appeals Process Overview: Decision



The Decision



After the Decision, The Chief Human Services Judge Will . . .



Issue the decision within 90 days of the appeal request

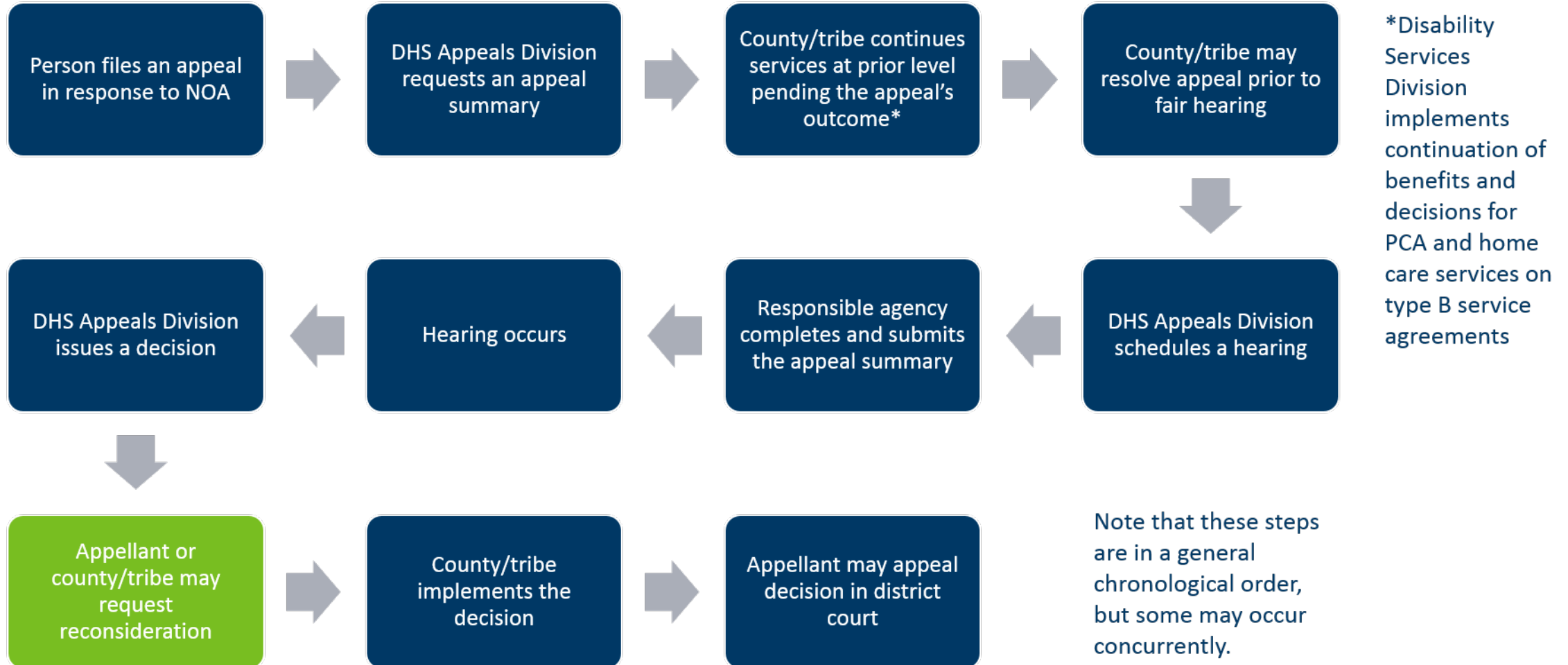


Send the final decision to the appellant




Notify all other involved parties, such as Aging and Disability Services, the county/tribe, and/or the MCO


Appeals Process Overview: Reconsideration



Reconsideration: County or Tribe Request



County or tribe requests reconsideration within 30 days.*



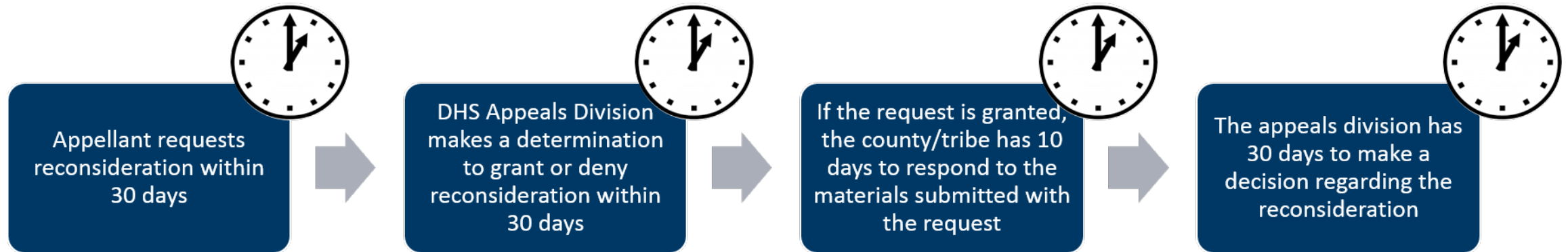
DHS Appeals Division makes a determination to grant or deny reconsideration within 30 days



The county/tribe sends the request to the Appeals Division Director and the appellant explaining why you are requesting reconsideration. Consult DHS for technical assistance.

*For decisions changing the state-set CDCS budget, request reconsideration. DHS Technical Assistance via encrypted email: DHS.CCAappeals@state.mn.us

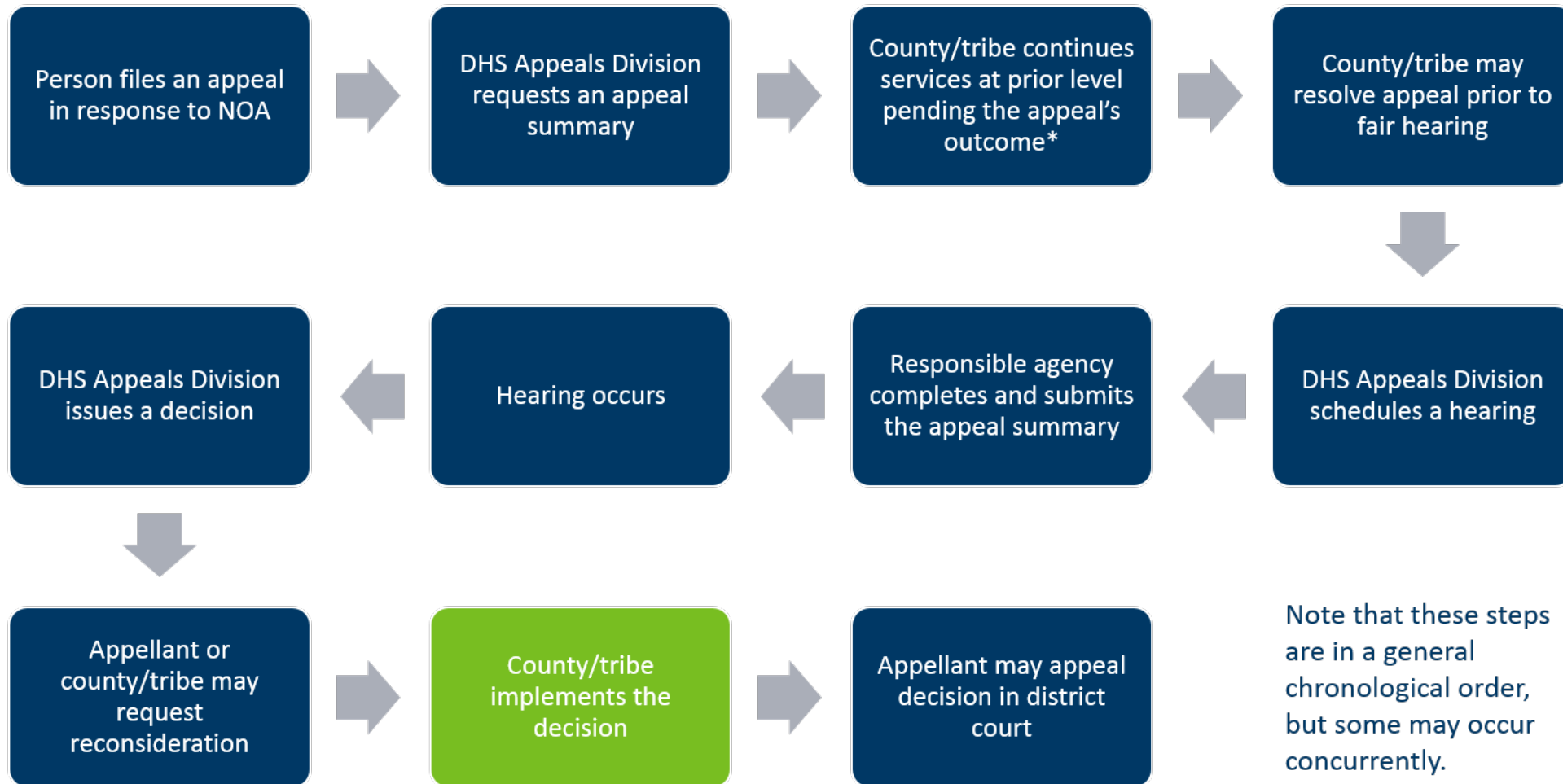
Reconsideration: Appellant Request



The DHS Appeals Division will notify all parties if the request is granted

DHS Technical Assistance via encrypted email: DHS.CCAappeals@state.mn.us

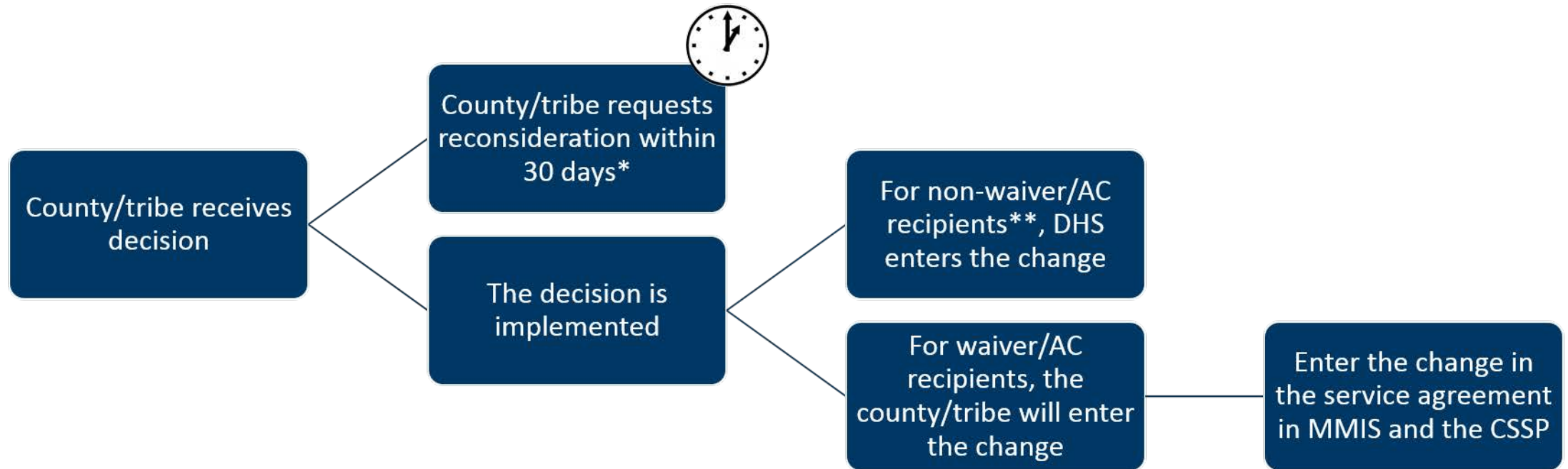
Appeals Process Overview: Implementation



*Disability Services Division implements continuation of benefits and decisions for PCA and home care services on type B service agreements

Note that these steps are in a general chronological order, but some may occur concurrently.

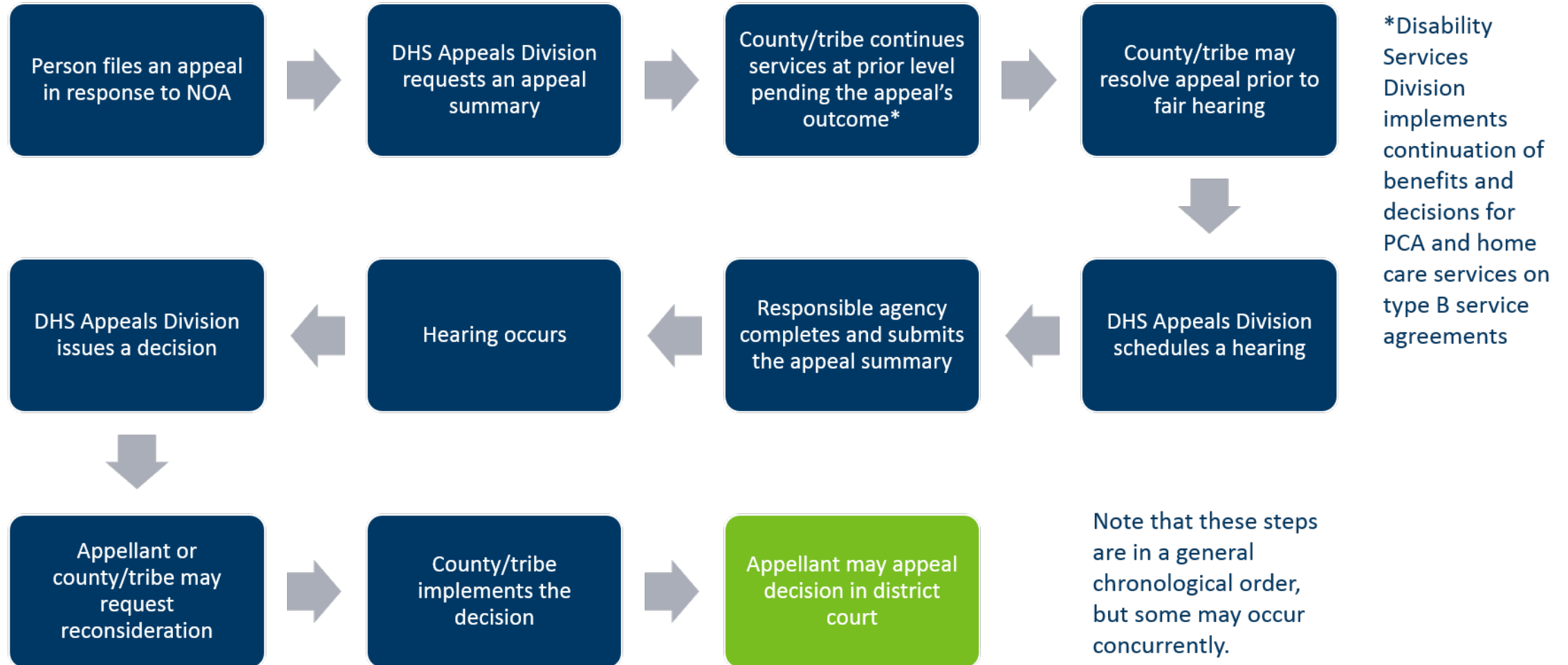
Implementing the Decision



*For decisions changing the state-set CDCS budget, contact DHS.CCAAppeals@state.mn.us via encrypted email for technical assistance.

** PCA and Homecare

Appeals Process Overview: District Court



Thank you!