State of Illinois
Department of Human Services

Notice of Individual's Right to Appeal - English Version

NOTICE OF INDIVIDUAL'S RIGHT TO APPEAL

Any individual requesting or receiving Medicaid waiver-funded services has the right to appeal a determination by Pre-Admission Screening or Individual Service and Support Advocacy (PAS/ISSA) agency staff that the individual does not meet the waiver programmatic eligibility criteria. The PAS/ISSA agency will notify the individual in writing of the decision and the process to appeal.

Any individual receiving Medicaid waiver-funded services has the right to appeal termination of waiver services authorized by the DHS Division of Developmental Disabilities or reduction of waiver-funded services by the individual service planning team or by the DHS Division of Developmental Disabilities. The qualified mental retardation professional (QMRP) who convened the team or the Division of DD will notify the individual in writing of the decision and the process to appeal.

The process is defined more fully in the Department's Medicaid waiver rule (59 ILL. Adm. Code 120.110) and in the HFS appeal rule (89 ILL. Adm. Code 104.70).

The individual or legal guardian must submit a written request for appeal to the Department of Healthcare and Family Services (HFS) at the address below within 60 calendar days after the date the notice advising the individual of the above actions is received. This 60-day limitation does not apply if the PAS/ISSA agency, the Division of Developmental Disabilities or the qualified mental retardation professional (QMRP) who convened the individual services planning team fails to notify the individual in writing of the decision or of the time limit.

If an appeal request is received within 10 calendar days after receipt of the notice of action, the decision in the notice shall be stayed, pending the results of the appeal.

The appeal process includes a review by an impartial hearing officer appointed by HFS. The HFS, as the single State Medicaid agency, will make the final administrative decision for persons in the Medicaid waivers.

For more information contact:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
401 South Clinton Avenue 6th Floor
Chicago, Illinois 60607
Telehpone: (312) 793-2636

I have read this form, or it has been read to me, and I have been given an opportunity to ask any questions I may have regarding my right to appeal under the Medicaid Home and Community/Based Services Waiver(s)

Name of Individual: ______________________________ Date: ______________

PLEASE PRINT

Signature of Individual or Guardian: ______________________________

Signature of Witness: ______________________________