State of Illinois Department of Human Services
Division of Developmental Disabilities

Notice of Individual's Right to Appeal Medicaid Waiver Determinations

Any individual requesting or receiving Medicaid waiver-funded services has the right to appeal a denial (including a determination of eligibility), termination, suspension, or reduction of the waiver-funded services. The Qualified Intellectual Disability Professional (QIDP) who convened the individual service planning team or the Division of Developmental Disabilities (DDD), whichever entity or agency took the above-mentioned action, will notify the individual in writing of the decision and process to appeal.

The PAS/ISSA agency is responsible for submitting a complete packet that will be used in the review process for a determination regarding the specifics of the case. The packet must include a signed written request by the individual/ guardian. The packet must be submitted within 60 calendar days of notice received of actions listed above.

The 60-day limitation does not apply if the PAS/ISSA agency, DDD, or the QIDP fails to notify the individual in writing of the decision or of the time limit**.** The written request for appeal should be submitted to:

Department of Human Services
Division of Developmental Disabilities
Medicaid Appeals Section
600 East Ash Street, 3rd Floor Building 400
Springfield, IL 62703

The DDD has 30 working days to complete an informal review of the appeal case. The DDD must then notify the individual and/or guardian of the decision within 10 working days of that determination. Should the individual and/or guardian disagree with the determination by the DDD, they have the option of requesting an administrative hearing with the Department of Healthcare and Family Services to review the DDD's decision.

For more detail on appeals and fair hearings, please see Medicaid waiver rule: http://www.ilga.gov/commission/jcar/admincode/059/059001200C01100R.html and the Administrative Hearings rule: 80 Ill.Adm.Code 104.7.

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: _____
(Please Print)

Signature of Individual/Guardian: _____ Date: _____