Washington State Department of Social & Health Services
ADSA Aging & Disability Services Administration

HOME AND COMMUNITY SERVICES (HCS)
AREA AGENCY ON AGING (AAA)

HCS/AAA PLANNED ACTION NOTICE

DATE OF NOTICE
PROGRAM
CLIENT ID:

Dear:

Effective _____ , your services will be:

☐ Approved ☐ Changed ☐ Continued ☐ Increased ☐ Withdrawn ☐ Denied
☐ Reduced ☐ Terminated ☐ Suspended

This action is being taken per:

☐ WAC 388-106-
☐ Adult Day Health (ADH) WAC 388-71-0702, WAC 388-71-0706, WAC 388-106-0810, WAC 388-106-0815
☐ Other:

You have been assessed for eligibility for home and community services in accordance with Chapter 388-106 of the Washington Administrative Code (WAC).

☐ Your assessment determined that you are not eligible for services.

☐ Your assessment determined that you are in classification group _____ and are eligible for _____ hours of in-home care through the _____ (COPES/MNIW/MPC/Statefunded) program.

☐ Your assessment determined that you are in classification group _____ and are eligible for a daily residential rate of $ _____ through the _____ (COPES/MNRW/MPC/State funded) program.

☐ Authorizing ADH Intake/Evaluation and _____ days/week for up to 10 paid service days for _____ nursing and/or _____ rehabilitative staff to evaluate if enrollment can occur at _____ ADH center.

☐ Authorizing ongoing ADH services _____ days/week for nursing and/or _____ rehabilitative services based on case manager eligibility determination at _____ ADH center for _____ (Date) to _____ (Date)

The above determination is based on the information contained in the attached Service Summary and Assessment Details.

☐ Other Action. The action, per WAC(s) is being taken because:

You have the right to ask for a Fair Hearing if you disagree with this action. You have ninety (90) days from the date you receive this notice to request a hearing. To request a Fair Hearing, you may write to the OFFICE OF ADMINISTRATIVE HEARINGS, PO BOX 42489, OLYMPIA WA 98504-2489.

If you are currently receiving benefits through the above noted program, **you will be eligible to have CONTINUING BENEFITS if you request a Fair Hearing by the effective date or the end of the month in which the effective date occurs.** If the Department action is upheld in the Fair Hearing, you may have an overpayment for benefits received during this period which you will have to repay. You will not have to repay more than sixty (60) days worth of benefits. If you do not want to have CONTINUING BENEFITS, you must notify the person who signed this letter in writing.

You also have the following rights: 1) to be represented (you may be eligible for free legal assistance); 2) to request a copy of your file and all information relied upon by the department in determining your benefits; 3) to submit documents in evidence; 4) to testify at the hearing and to present witnesses to testify on your behalf; and 5) to cross examine witnesses testifying for the department. For further information, please request a pamphlet DSHS 22-092(X)) from the person signing this letter. If desired, call:

_____

Sincerely,

_____

SOCIAL WORKER'S/CASE MANAGER'S SIGNATURE

HCS/AAA NAME AND ADDRESS