**UPCAP Clear Logo.emfAdequate Action Notice**

**Post Assessment Decision**

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| Date: | |  | Dear: |  |  |
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| **Please see checked box below. *Only the checked box below applies.*** | | | | | |
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|  | Following a review of your service needs, and based on our initial assessment, it has been determined that **your service needs can be met without waiver services**, therefore we will not be opening you to the MI Choice Waiver Program.  The legal basis for this decision is UPCAP's Waiver Contract with the Michigan Department of Community Health, Attachment K, Waiver Program Operating Criteria, Sect. VIII: Participant Care Planning, paragraphs E and F.  \*If you do not agree with this decision you may request a **Medicaid Fair Hearing.** To request a Medicaid Fair Hearing, complete the enclosed “*A Request for an Administrative Hearing"* form (DCH-0092) and envelope. | | | | |
| **MAIL TO:** Administrative Tribunal, Michigan Department of Community Health, | | | | | |
| PO Box 30763, Lansing, MI 48909 | | | | | |
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|  | Following a review of your long term care needs, it has been determined that you do **not qualify for MI Choice Program** services based on the Michigan Medicaid Nursing Facility Level of Care Determination. You did not qualify under any of the following eligibility categories: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies.  The legal basis for this decision is 42 CFR 440.230(d). \*If you do not agree with this action, you may request the following:  **Immediate Review:** To obtain an Immediate Review, you must contact the Michigan Peer Review Organization (MPRO) at 800-727-7223 before 12:00 PM (noon) of the next business day following your receipt of this notice.  **Medicaid Fair Hearing:** To request a Medicaid Fair Hearing, complete the enclosed “*A Request for an Administrative Hearing*” form (DCH-0092) with the enclosed envelope. | | | | |
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| **MAIL TO:** Administrative Tribunal, Michigan Department of Community Health, | | | | | |
| P.O. Box 30763, Lansing, MI 48909 | | | | | |
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| ***The Medicaid Fair Hearing Request must be: Received within 90 calendar days of the date of this notice, in writing, and signed by you or a person authorized to sign for you.*** | | | | | |
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| If you have any questions regarding the above, please call me at (906) | | | | | |
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| Sincerely, | | | | | |

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|  | - UPCAP Care Manager |