(*MI Choice Waiver Agency* Letterhead)

Adequate Action Notice

Date:

Name: Address: City, State, Zip code

Dear ____________________:

This notice is to inform you that a Level of Care Determination (LOCD) conducted on (*date*), determined that you **do not meet** the functional eligibility requirement for Medicaid long-term care services. The legal basis for this decision is 42 CFR 440.230(d). Enclosed you will find a copy of your LOCD.

If you do not agree with this action, **you may do either or both of the following**:

HOW TO REQUEST A SECONDARY REVIEW REQUEST: You have a right to request a **Secondary Review** from the Michigan Peer Review Organization (MPRO). This review will look at the same information we used, as well as other possible needs you may have. To request a Secondary Review, contact MPRO **within 3 (three) business days** following the receipt of this notice at **800-727-7223**.

HOW TO REQUEST A MEDICAID FAIR HEARING REQUEST: You have a right to a Medicaid Fair Hearing. You have **90 calendar days** from the date of this notice to request a Medicaid Fair Hearing by mail or fax. The request must be in writing and signed by you or a person authorized to sign for you. To request a Medicaid Fair Hearing, complete a **"Request for an Administrative Hearing" (DCH-0092) form and mail it to**:

Request for Administrative Hearing
Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
PO Box 30763
Lansing, Michigan 48909

Or **fax** it to:

FAX NUMBER: **517-763-0146**

If you have any questions, you can talk to *<supports coordination/staff person name>* at our agency.

Sincerely,

(provider representative)

Attachments:

1. LOCD
2. Secondary Review – Exception Criteria Information Sheet
3. Request for an Administrative Hearing (DCH-0092) form