Eric Holcomb, Governor
State of Indiana

Office of Medicaid Policy & Planning
402 W. WASHINGTON STREET
INDIANAPOLIS, IN 46207

Case: C-(CaMSS Case ID)

DATE

Waiting List Eligibility Date: **(DATE of the original LOC for waiver)**

Name of Individual
Address 1
Address 2
City, State, ZIP

RE: **PathWays Home and Community-based Services (HCBS) Waiver waiting list placement**

Dear NAME:

On (DATE of LOC Assessment was completed), it was determined you met the required level of care and are interested in home and community-based services through the PathWays Waiver.

The PathWays Waiver has a maximum capacity each year for individuals to receive services through the waiver. This number is determined in the state's PathWays Waiver Application which is approved by the Centers for Medicare and Medicaid Services (CMS). FSSA has reached the allowed limit and must implement a waiting list for individuals seeking to access services through the PathWays Waiver.

You have been placed on the waiting list for the PathWays Waiver. Your waiting list eligibility date is **(DATE of the original LOC for waiver**). This date represents your original level of care for the waiver.

While you are on the waiting list, you are responsible for notifying (Insert AAA Name and phone #) of any change in your address or other contact information. Your placement on the waiting list does not guarantee access or receipt of services. If access to services becomes available, you will be contacted by (Insert AAA Name) with information on how to continue the enrollment process for the PathWays Waiver. The AAA will attempt to contact you up to four (4) times including once through a letter. If the AAA is unable to contact you after these attempts, you will be removed from the waiting list.

This is considered an administrative action by the State of Indiana appealable to an administrative law judge from the State of Indiana Office of Administrative Law Proceedings. If you disagree with this determination of being placed on the waiting list for the PathWays Waiver, you have a right to appeal by following the procedures in the attached appeal rights.

If you have questions, some may be addressed in the enclosed Frequently Asked Questions, or you can review the resources available at https://www.in.gov/fssa/medicaid-strategies. Information on invitations to the waiver is available at https://www.in.gov/fssa/ddrs/information-for-individuals-and-families/hcbs-waiver-waiting-list-information/. If you still have questions about the information in this notice, you can contact your local AAA at https://www.in.gov/fssa/da/files/AAA_Map.pdf, call 800-713-9023, or visit https://www.in.gov/fssa/inconnectalliance/.

Sincerely,

Cora Steinmetz, Director, Office of Medicaid Policy & Planning
Enclosure: Appeal Rights, Frequently Asked Questions
cc: File

Appeal Rights for Home and Community-Based Services

You have the right to appeal the enclosed decision and have a fair hearing. The enclosed letter explains the decision regarding your application for or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a fair hearing.

How to request an appeal:
Your request for an appeal must be received by close of business no later than 30 days from the receipt of the enclosed letter. You must also list with reasonable particularity the reason(s) for requesting the appeal.

To file an appeal, please sign, date and return this form to:

AOPA Appeals
FSSA Office of General Counsel
MS 27
402 W. Washington Street, Room W451
Indianapolis, IN 46204

Or send the form via fax to:
(317) 232-1133

If you are unable to sign and date this form, you may have someone assist you.

You will be notified in writing by the Indiana Family and Social Services Administration, Office of Hearings and Appeals of the date, time, and location for the hearing. Prior to the hearing, you have the right to examine the entire contents of your case record maintained by your care manager.

You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other person. You will have the opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.

I wish to appeal the above decision for the following reasons:

If you require more space, include additional pages.

Name of Applicant: _____

Signature of Applicant/Guardian: _____

Date: _____ Reference: CaMss Case ID

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