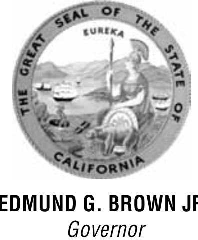
State of California-Health and Human Services Agency

Department of Health Care Services

P.O. Box 989009, West Sacramento, CA 95798-9850



TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

Month Year

JOHN SAMPLE
1234 SAMPLE STREET
ANYTOWN CA 90000

NOTICE OF ACTION

Denial of Eligibility for Community-Based Adult Services (CBAS)

Dear:

We are sending you this letter to let you know about important information. You have been found to be ***not eligible*** for Community-Based Adult Services (CBAS). You can appeal this decision.

CBAS is a Medi-Cal benefit that will begin on March 1, 2012. CBAS allows eligible people in Medi-Cal to get skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, transportation, and case management in one central location. Because the Department of Health Care Services entered into a settlement agreement in the *Darling, et al. v. Douglas, et al.* lawsuit, Adult Day Health Care (ADHC) will end on February 29th, 2012, and CBAS will begin the next day. You can read the settlement agreement online at http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx.

You were assessed for eligibility for CBAS because you receive, or recently received, ADHC services at an ADHC center. DHCS nurses have met with you (or have tried to meet with you) to assess your eligibility for CBAS.

This Notice of Action is to let you know that you have been found ineligible for CBAS because you:

- Do not need enough nursing to meet "Nursing Facility Level of Care A" (NF-A); **or**
- Do not have a moderate to severe cognitive impairment, including moderate to severe Alzheimer's Disease or other dementia; **or**
- Do not have a developmental disability; **or**
- Do not have a mild to moderate cognitive disability, including Alzheimer's or dementia AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; **or**
- Do not have a chronic mental illness or a brain injury AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene; OR one need from the above list and one of the following: money management, accessing resources, meal preparation, and transportation.

For more information about the eligibility criteria for CBAS, please see the settlement agreement online at http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx.

What happens now?

Although you are not eligible to receive CBAS, **you *are* eligible to receive Enhanced Case Management services, which will help you to find services.**

- If you ***are enrolled*** in a Medi-Cal managed care plan, your plan will call you or you can call your health plans member services. Your plan will provide you with Enhanced Case Management services. A list of health plans member services can be found at http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx
- If you ***are not enrolled*** in a Medi-Cal managed care plan, APS Healthcare will call you or you can call APS Healthcare at 1-800-693-6735. They will provide you with Enhanced Case Management services.

Does this change my Medi-Cal or Medicare eligibility?

This Notice does not affect your eligibility or receipt of other Medi-Cal or Medicare services.

What if I disagree with the decision?

Your State Hearing Rights

If you disagree with this denial, you have the right to appeal the decision and request a State Hearing (Section 51014.1 of Title 22 of the California Code of Regulations). Please see the enclosed "*Your State Hearing Rights*" and "*State Hearing Request*" form for more information on State Hearing rights and the best way to request a State Hearing.

If you file an appeal of the Department's determination of your ineligibility for CBAS, you will not receive CBAS services during your appeal because CBAS is a new program. Instead, you will receive Enhanced Case Management services while your appeal is going on.

Who should I call if I have questions?

If you have any questions or concerns about this notice, or would like information or help in filing your appeal, please call Disability Rights California at (800) 776-5746, TDD/TTY (800) 719-5798, or you can write to:

Disability Rights California
1330 Broadway, Suite 500
Oakland, CA 94612
Darling@disabilityrightsca.org

Your State Hearing Rights

To Ask for a State Hearing

- You only have 90 days to ask for a hearing.
- The 90 days starts the day after we mailed this notice.

If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

To Get Help

If you do not want to attend the hearing alone, you may bring a friend, relative, an attorney, or anyone else that you choose. You may get free legal help at your local legal aid office or welfare rights group.

You can ask about your hearing rights or free legal aid at the state information numbers below. These numbers can be very busy. You may get a message asking you to call back later.

Call Toll Free:	1-800-952-5253
If you are deaf and use TDD/TTY call:	1-800-952-8349

How to Ask for a State Hearing

The best way to ask for a hearing is to fill out the back of this form and send to:

Mail: California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

Fax: 1-916-651-5210 or 1-916-651-2789 (Attention: State Hearing Support)

You may also call:

Phone: 1-800-952-5253 or 1-800-743-8525
TDD/TTY: 1-800-952-8349

Note

The State Hearings Division cannot accept requests for a state hearing via e-mail.

Other Information

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the U.S. Department of Health and Human Services.

State Hearing Request

I am requesting a State Hearing because of an action taken by the Department of Health Care Services

Name: ______________________________

Address: ______________________ Zip code: __________

Phone: ______________________________

Social Security Number or Medi-Cal ID number: ______________

(Your hearing may be delayed if this number is not provided)

I do not agree with:

☒ Determination of ineligibility for Community-Based Adult Services (CBAS)

Here is why

Note: If possible, attach a copy of the Notice of Action letter to this form. If you need to provide more information, please use the space below:

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(If you need more space, please use another piece of paper. Make a copy for your records)

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

Check any box(es) that apply to you:

☐ ❶ I want the person named below to represent me. He/She can see my medical records related to this hearing, come to the hearing, and speak for me.

Name: ______________________ Phone: __________

Address: ______________________________

☐ ❷ I need a free interpreter (a relative or friend cannot interpret for you at a hearing).
My language or dialect is: ______________

☐ ❸ I would like a telephone hearing.

☐ ❹ I want to attend the hearing and I need the following ADA accommodations (e.g., wheelchair accessible, large print).

☐ ❺ **Urgent**. I need a quick decision and cannot wait 90 days. Please explain below:

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My Signature ______________________ Date: __________

After you complete this form, make a copy for you records.