Requesting an Appeal

Step 1:

You and your guardian, if applicable, have the right to request an appeal if you feel a Department decision was not arrived at fairly. Decisions that can be appealed include:

- A denial of Developmental Disability (DD) or ICF/ID Level of Care eligibility;
- An individualized budget you feel was incorrectly calculated; or
- An Individual Support Plan (ISP) or Support and Spending Plan (SSP) that was totally or partially denied.

Step 2:

In each of the above cases, either an Independent Assessment Provider (IAP) or Care Manager will mail a Notice to you and your guardian (if applicable), that shows the outcome of the eligibility determination, budget calculation, or plan review process. This Notice also provides the timeline for requesting an appeal and where the request should be sent.

Appeals requests are sent to Administrative Procedures Section (APS). Any
appeal request received more than twenty-eight (28) days after the Notice was
mailed will not be processed.

Step 3:

Once an appeal request is received by APS, it is forwarded to the Bureau of Developmental Disability Services (BDDS) to review. BDDS may contact you or your Plan Developer/Support Broker if they have additional questions about your appeal before recommending it be scheduled for hearing. If you are concerned that your request for appeal may not have been received, you may contact APS to find out.

- If you are appealing your calculated budget, you do not need to submit a plan. You will want to wait until a decision has been made regarding your appeal before developing a new plan.
- If you are currently receiving services, you may request an extension of your existing plan to avoid a lapse in services should the hearing process extend past the end date of your current plan. If you are receiving traditional services, your Plan Developer may contact the Care Manager to request an extension of your existing ISP. If you are self-directing your services, your Support Broker may contact the Care Manager to request an extension of your existing SSP.
- If you are appealing a totally or partially denied service plan, you may request
 an extension of your existing plan to avoid a lapse in services should the hearing
 process extend past the end date of your current plan. If you are receiving
 traditional services, your Plan Developer may contact the Care Manager to
 request an extension of your existing ISP. If you are self-directing your services,
 your Support Broker may contact the Care Manager to request an extension of
 your existing SSP.
- If you do decide to request an extension of your existing plan, you may be required to pay back the additional dollars received by providers on your behalf if the Department's decision is upheld through the appeal process.

Step 4:

Once the Department has recommended an appeal be set for hearing, your case will be assigned to a Hearing Officer. You will receive a 'Notice of Telephonic Hearing' from the Hearing Officer that outlines the date/time and toll-free telephone number to call on the day of the hearing. The Notice also gives information on the use of witnesses and the process for submitting any exhibits (items/information that show your side of the case) you want to present at the hearing to support your disagreement with a Department decision.

Step 5:

Once the hearing has been held, a decision is made by the Hearing Officer. The Hearing Officer is only able to rule on whether or not the Department followed their processes to support the decision they made. The Hearing Officer is unable to approve the eligibility of a participant, modify the budget, or approve denied services on a plan. Based on the testimony at the hearing, the Hearing Officer may:

- Uphold the Department's decision; or
- Remand the matter back to the Department to update assessment documents, re-calculate the participant's budget or re-examine a service denial.

If the Hearing Officer upholds the Department's decision regarding:

- A denial of eligibility: You will not be eligible to receive DD services.
- A calculated budget: You will need to submit a plan within the assigned budget.
- A denial of services: You may modify the plan to adjust services accordingly or you can choose not to receive DD services.

Step 6:

Notification of the Hearing Officer's decision will be sent to you within thirty (30) days after the hearing is held. This Notice is called the 'Findings of Fact, Conclusions of Law, and Preliminary Decision'. This document will outline the facts presented at the hearing and the Hearing Officer's decision.

Step 7:

If either you or the Department disagrees with the Hearing Officer's decision, the party who does not agree will have fourteen (14) days from the date of the decision to request a Director's Review. The request for a Director's Review must be submitted to Administrative Procedures Section. The Director or his designee will then review the facts of the case and decide whether the Hearing Officer's decision should be upheld.

Step 8:

If either you or the Department disagrees with the decision made through the Director's Review, the party who does not agree will have the option to file an appeal with District Court. The Department cannot extend a plan while an appeal is pending in District Court.

**If at any time during this process you choose to withdraw your appeal, please contact your Care Manager.