summit DD
Developmental Disabilities Board

NOTICE OF YOUR RIGHTS TO MEDICAID DUE PROCESS

(Modification of JFS07334, JFS04065 and JFS04074)

NAME _____ DELIVERY METHOD: ☐ Hand Delivered ☐ Email ☐ US Mail

ADDRESS _____ TYPE OF WAIVER: _____

CITY _____ STATE _____ ZIP _____ BIRTHDAY _____

THIS LETTER IS TO INFORM YOU OF ACTIONS THAT HAVE HAPPENED OR ARE BEING PROPOSED REGARDING YOUR MEDICAID WAIVER:

☐ YOUR MEDICAID WAIVER SERVICE WAS **APPROVED.**

EFFECTIVE DATE _____

NAME OF SERVICE _____

IF YOU AGREE WITH THIS, YOU DO NOT NEED TO DO ANYTHING FURTHER.

☐ THE MEDICAID WAIVER SERVICE OR STATUS YOU REQUESTED WAS **DENIED**.

EFFECTIVE DATE _____

NAME OF SERVICE _____

REASON FOR DENIAL _____

RULE 5123-9-01:48

☐ **TERMINATION/REDUCTION**

A MEDICAID WAIVER SERVICE YOU CURRENTLY HAVE WILL BE: ☐ TERMINATED ☐ REDUCED

EFFECTIVE DATE _____

NAME OF SERVICE _____

THIS WILL BE TERMINATED/REDUCED FROM: _____ TO: _____

If you do not agree with this proposal and request a hearing within 15 days of the mailing/ delivery date listed above, this action will not be taken until a state hearing with the Ohio Department of Job & Family Services is held and a decision has been made. For a full explanation of your rights and what you can do to appeal, see page two of this notice.

REASON FOR TERMINATION/REDUCTION: _____

RULE: 5123-9-01:48

IF YOU AGREE: There is nothing that you need to do. DO NOT sign and return this form.

IF YOU DISAGREE: Please follow the instructions on this page. You can contact your Service & Support Administrator at Summit County Developmental Disabilities Services with any questions that you might have.

YOUR SERVICE & SUPPORT ADMINISTRATOR: _____ PHONE NUMBER: _____

NAME _____ DELIVERY DATE _____

YOUR RIGHT TO A STATE HEARING

If you disagree with this action, you have the right to a state hearing. A state hearing lets you or your representative (lawyer, friend or relative) give your reasons against this action. The agency proposing the action will also attend the hearing to present its reasons. A hearing officer from the Ohio Department of Job and Family Services will decide whether you or the county agency is right. If you win your hearing the action may not be taken or you could get an increase in your benefits. If you lose your hearing, you may have to pay back money or food stamps that you received but were not eligible to receive. You do not need to return this form if you agree with the proposed action.

If someone else makes a written hearing request for you, it must include a written statement, signed by you, telling us that person is your representative. Only you can make a request by telephone. If you want information on free legal services, but don't know the number of your local legal aid office, you can contact your local Legal Aid office in Ohio by calling 1-866-529-6446.

☐ I WANT A **COUNTY CONFERENCE WITH COUNTY OF SUMMIT DEVELOPMENTAL DISABILITIES BOARD**.

_____ _____ _____

SIGNATURE DATE PHONE NUMBER

☐ I WANT A **STATE HEARING**.

SIGNTURE DATE PHONE NUMBER

☐ I WANT A **COUNTY CONFERENCE WITH COUNTY OF SUMMIT DEVELOPMENTAL DISABILITIES BOARD & A STATE HEARING**.

_____

SIGNTURE DATE PHONE NUMBER

Fill out this information only if it applies to your situation. (Check all that apply)

☐ **I want to do my hearing by telephone**. The phone number to call is:

☐ **I need an interpreter at my state hearing**. The language needed is:

☐ **I am not available** for a hearing on:

(Please note that ODJFS may not be able to give you the preferred date.)

This person has agreed to help me with my state hearing (my "authorized representative")

Name _____ Phone

Address _____ Fax _____

City _____ State _____ Zip _____

ODJFS must receive your request 90 days from the date this notice was mailed/delivered to you. You must choose one of the following ways to send this state hearing request to us. You should keep proof of when and how you sent this hearing request to us.

Please only submit your hearing request one time and include both pages of this notice.

Electronically Submit the hearing request to the Bureau of State Hearings SHARE portal at https://hearings.jfs.ohio.gov/SHARE Log into the SHARE portal using your Ohio Benefits ID and password to submit your request. (If you do not have an Ohio Benefitsaccount, sign up at ssp.benefits.ohio.gov; or

Email the ODJFS Bureau of Sate Hearings at bsh@jfs.ohio.gov. In the subject line, put "State Hearing Request". In the message, put all of the information from the boxes at the top of this page and any additional information below; or

Phone the ODJFS Consumer Access Line at 866-635-3748. Follow the instructions for State Hearings. Mention this notice or;

Fax - Fax both pages of this notice to the ODJFS Bureau of State Hearings at 614-728-9574; or

Mail - Mail both pages of this notice to ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

Contact your caseworker - It is better to send this request using one of the methods above. But you may give this page (completed and signed) to your caseworker. Or, you may phone your caseworker. Mention this notice.