OFFICE OF DEVELOPMENTAL PROGRAMS
NOTICE OF ELIGIBILITY OR SERVICE DETERMINATION AND
FAIR HEARING REQUEST FORM (DP 458)

If you (the individual as defined in ODP Bulletin 00-26-01) are applying for ODP services or if you object to an action taken by the Administrative Entity (AE) or the Office of Developmental Programs' (ODP) Bureau of Supports for Autism and Special Populations (BSASP) that adversely affects your application or authorization for Waiver services, you have the right to appeal the determination and request a Fair Hearing before the Department of Human Services, Bureau of Hearings and Appeals (BHA). You will not be granted a hearing if the action taken was caused solely by state or federal law or regulation requiring a change in the eligibility for or type of services available under the waiver program.

You may file an Appeal and have a Fair Hearing when the following occurs:

- You are determined to meet an Intermediate Care Facilities for Persons with Other Related Conditions (ICF/ORC) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) level of care, are enrolled in Medical Assistance, and was not offered a chance to express a service delivery preference for either waiver-funded or ICF/ID or ICF/ORC services on the DP 457 form.
- You are not determined to not meet an ICF/ID or ICF/ORC level of care.
- You are determined not eligible for Targeted Support Management or waiver enrollment.
- A decision was made to deny you the choice of a willing and qualified provider.
- A decision was made to deny a requested service.
- A decision was made to suspend, reduce, or terminate a service that is authorized on your Individual's Individual Support Plan (ISP).

You have the right to represent yourself or to have someone else represent you. A representative of the Agency who made the service determination, or your Supports Coordination Organization as appropriate, will refer you to agencies that may be able to provide legal help if you request. During the Fair Hearing process, you or your representative can present the reasons why you think the proposed action is incorrect and present evidence and/or witnesses to support your case.

You may consult with anyone of your choosing and/or an attorney for assistance in determining whether to appeal.

You also have the right to examine the information that was used to make the decision or take the action you are appealing and all information that will be introduced at the hearing. There may be a charge for copies of these documents.

Please read below for the instructions on how to fill out the DP 458 Form. The Form begins on page 5 of this document.

INSTRUCTIONS

The Instructions and Form DP 458 should be used with the guidance in Attachment 1 of ODP Bulletin 00-26-01 which outlines an individual's right to appeal and have a fair hearing when applying for or receiving waiver-funded services. All documents, including the DP 458, **must be sent directly to the Agency that made the determination regarding your application or authorization for Intellectual Disability/Autism (ID/A) or Adult Autism Waiver, TSM, ICF/ID or ICF/ORC services.**

Roles for Completing the Form

The Form DP 458 is split into several sections to be completed by one of the two following roles. The form indicates which role completes that section.

> **Agency:** Either the Administrative Entity (AE) for individuals enrolled in one of the ID/A Waivers or applying for services, or ODP's Bureau of Supports for Autism and Special Populations (BSASP) for individuals enrolled in the Adult Autism Waiver (AAW).
>
> **Individual:** The individual to whom the form is addressed, or their representative.

Section I (To be completed by the Agency)

Enter the individual's name and address in this section.

Section II (To be completed by the Agency)

Enter the date (month, day, year) the Agency made the eligibility or service determination. Enter the Agency's name.

Eligibility

Left click or manually check the box next to the eligibility determination for which appeal and fair hearing rights are being provided, if applicable. If the determination is not regarding eligibility based on a Level of Care initial or re-evaluation, select the N/A option.

Enrollment

Left click or manually check the box next to the waiver in which the individual is currently enrolled or the services the individual is receiving. If the individual is not currently enrolled in a waiver or receiving services, select the N/A option.

Eligibility or Service Determination

Left click or manually check the box next to the eligibility or service determination. Enter the type and amount of service(s) being denied, reduced, terminated, or suspended. If an application for enrollment in a funding source is denied, enter the name of the funding source the individual applied for. If the Agency takes an action to reduce, terminate, or suspend services, the effective date must be at a minimum 10 calendar days from the date indicated in the box above Section 1.

Reason for Eligibility or Service Determination

Enter the reason why the particular eligibility or service determination was made for the individual. Include a reference to policies, regulations, and/or program requirements to support the decision.

Agency Contact Information

The Agency must enter a contact name, telephone number, and mailing address for the individual to use in the event of follow-up questions, concerns, and/or to submit a written appeal.

Section III (To be completed by the Agency)

Appeal Dates

This section includes the dates that the individual must submit an appeal request in order to have the appeal request processed and services continued, if the individual is currently receiving a service that is reduced, terminated, or suspended. For an advanced written notice, the individual's appeal must be received orally or via email, or postmarked if sent by postal mail by the date entered for "10 Days" for the individual to continue receiving services at the current level.

30 Days - Enter the date (month, day, year) that is 30 calendar days from the date entered in the box above section I.

10 Days - Enter the date (month, day, year) that is 10 calendar days from the date entered in the box above section I.

Section IV (To be completed by the Individual)

Reason for Appeal

The individual should fill out the reason they are filing an appeal. This should be based on the information in Section II of the DP 458 that was provided by the Agency. The individual should provide documentation to justify the reason for the appeal. BHA may issue a "Rule to Show Cause" for clarification of the issue in order to make the final decision of appealability.

Resolution Being Sought

The individual should clearly describe the outcome the individual desires from the appeal and fair hearing.

Expedited Fair Hearing

If an individual requests an expedited fair hearing, this section must be completed to indicate the reason. The individual is encouraged to provide additional documentation to help support the reason for the expedited fair hearing.

Conference Prior to the Hearing

The individual must check either the Yes or No box to indicate the individual's decision to request a voluntary, informal conference with the Agency that made the eligibility or service determination. The optional conference gives both the individual and the Agency the opportunity to discuss and attempt to resolve the issue prior to the official fair hearing.

Hearing Preferences

The individual must check the box for the type of hearing they prefer based on the available options through the BHA included in Section IV of this form. If the telephone hearing box is checked, the individual must include a telephone number.

Additional Support

This section needs to be completed if the individual is requesting any of the assistance indicated in the form and below in order to participate in a conference with the Agency and/or fair hearing.

- If the individual needs an interpreter, this box must be checked, and the language to be interpreted must be documented.
- If the individual needs an alternative form of communication, this box must be checked, and the alternative form of communication being requested must be documented.
- If the individual needs any other accommodation, this box must be checked, and the accommodation being requested must be documented.

Section V (To be completed by the Individual)

Individual's Information

The individual must include the date the DP 458 is being completed and the Individual's signature, telephone number, and address.

Representative's Information

If the individual has a representative assisting with the appeal and fair hearing process, this section must be completed by the representative, including the date and the representative's signature, telephone number, address, and the representative's relationship to the individual.

Section VI (To be completed by the Agency)

The Agency must complete this section when it receives an appeal form with Sections IV and V completed. This section lists the required documents to be submitted, and the amount of time the Agency has to submit those documents to BHA based on the type of fair hearing being requested.

Standard Fair Hearing Request

The Agency should check this box if the Expedited Fair Hearing subsection in Section IV of the DP 458 was not completed. If the standard fair hearing box is checked, the Agency should also check the boxes in the list below it to indicate which documents are included as part of the fair hearing request being submitted to BHA.

Expedited Fair Hearing Request

The Agency should check this box if the Expedited Fair Hearing subsection in Section IV of the DP 458 was completed. If the expedited fair hearing box is checked, the Agency should also check the boxes below to indicate which documents are included as part of the expedited fair hearing request being submitted to BHA.

The Agency will choose the appropriate ODP Regional Program Office to notify of the appeal based on the individual's county of registration.

Pennsylvania
Department of Human Services

Office of Developmental Programs Notice of Eligibility or Service Determinations and Fair Hearing Request Form

Date this notice was mailed:

SECTION I

This section must be completed by the Administrative Entity or ODP's Bureau of Supports for Autism and Special Populations.

Individual Name:

Individual Address:

SECTION II

This section must be completed by the Administrative Entity or ODP's Bureau of Supports for Autism and Special Populations.

On Insert Date the Insert Agency made the following eligibility or service determination:

Eligibility

Select the eligibility determination for which this form is being completed:

☐ Level of Care Initial Determination
☐ Level of Care Re-evaluation Determination
☐ N/A

Enrollment

The individual is either currently enrolled in or receives the following services :

☐ Adult Autism Waiver (AAW) ☐ Consolidated Waiver ☐ Community Living Waiver
☐ Person/Family Directed Supports Waiver ☐ Targeted Support Management (TSM) ☐ N/A

Eligibility or Service Determination:

Your eligibility/service delivery determination:

☐ Denial of: (identify specific service/eligibility being denied)

☐ Reduction of: (identify specific service(s) being reduced and the effective date)

☐ Termination of: (identify specific services(s) terminated and the effective date)

☐ Suspension of: (identify specific service(s) suspended and the effective date)

Reason for Eligibility or Service Determination:

This decision is made for the following reason(s) (include any policy, regulation, and/or program requirement that supports the decision):

Agency Contact Information:

If the individual has any questions or concerns regarding this notice, or if the individual is submitting a written appeal, please contact:

Agency/Representative Name: Telephone number:

_____ (_____) - _____ - _____

Agency Mailing Address:

SECTION III

This section must be completed by the Administrative Entity or Bureau of Supports for Autism and Special Populations.

Appeal Dates:

30 Days - (Insert Date)

10 Days - (Insert Date)

SECTION IV

This section is to be completed by the individual.

Reason for Appeal:

What is the reason(s) for your appeal? Please be specific:

(Please attach supporting documentation or information. Use additional paper if necessary.)

Resolution Being Sought:

What outcome would you like to see happen to resolve the issue being appealed? Please specify:

(Use additional paper if necessary.)

Expedited Fair Hearing:

Please explain how the normal time for deciding an appeal would jeopardize your health, welfare, and/or independence. Please attach any relevant supporting documentation or information.

Agency Conference:

☐ Yes – I would like to discuss my appeal with the Agency who made the service determination I am appealing prior to the hearing.

☐ No – I do NOT want to discuss my appeal prior to the hearing.

Hearing Preferences:

Several types of hearings are available. Please indicate your preference for attending below:

☐ Telephone Hearing – The Administrative Law Judge will call you, your witnesses, anyone helping you, and a representative from the Agency who took the action/made the determination being appealed. Include the telephone number where you can be reached for the hearing:

(___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___

☐ Assisting Agency Telephone Hearing – You will be at the office of the Agency who took the action/made the determination being appealed. The Administrative Law Judge will call the representative from the Agency who is with you, as well as any witnesses and anyone helping you who is not at the same location as you and the Agency representative.

☐ Face-to-Face Hearing – You, your witnesses, anyone helping you, and a representative from the Agency who took the action/made the determination being appealed will be in a hearing room at an assigned BHA office with an Administrative Law Judge.

☐ Hybrid Face-to-Face Hearing – You, your witnesses, anyone helping you, and an Administrative Law judge will be in a hearing room at an assigned BHA office with an Administrative Law Judge. The judge will call a representative from the Agency who took the action/made the determination being appealed.

Additional Support:

If you need additional support to participate in the conference with the Agency and/or fair hearing because you speak a language other than English or needs help because of a hearing loss or disability, you must make that request before the conference and/or fair hearing. There will be no cost to you for this service.

Check here if you need an interpreter: ☐ What language?

_____

Check here if you need an alternative form of communication: ☐ If so, please specify:

_____

Check here if need any other accommodations: ☐
What accommodation(s) do you need?

_____

SECTION V

This section is to be completed by the individual.

Individual:

Date	Individual Signature	Telephone Number

Individual Address

Individual's Representative (if applicable):

Date	Representative Signature	Telephone Number

Representative Address

Printed Name of Representative and Relationship to Individual

SECTION VI

This section must be completed by the Administrative Entity or ODP's Bureau of Supports for Autism and Special Populations.

Standard Fair Hearing

☐ Standard Fair Hearing Request
Within three business days of receipt of the appeal and fair hearing request, the Agency must submit the following to BHA:

☐ The completed DP 458 form,

☐ The BHA Appeal Cover Sheet,

☐ The Agency's supporting documentation for the eligibility or service determination, and

☐ Any supporting documentation from the individual related to the appeal and fair hearing process.

Expedited Fair Hearing

☐ Expedited Fair Hearing Request
Within one business day of receipt of the expedited appeal and fair hearing request, the Agency must submit the following to BHA:

☐ The completed DP 458 form,

☐ The BHA Appeal Cover Sheet,

☐ The Agency's supporting documentation for the eligibility or service determination, and

☐ Any supporting documentation from the individual related to the appeal and fair hearing process.

Additionally, within three business days of receipt of the appeal and request for an expedited fair hearing, the Administrative Entity must notify the appropriate Office of Developmental Programs Regional Program Office of the appeal and request for an expedited fair hearing.