**[MCO Letterhead]**

**[Template for Notice of Change in Level of Care]**

<<Date mailed>>

<<Member’s name>>

<<Street address>>

<<City>> <<State>> <<Zip Code>>

Subject: Your Level of Care Has Changed

Dear <<Member’s name>>:

This letter notifies you that there has been a change in your level of care. Your level of care is an assessment of how much assistance you need to perform certain daily living activities. <<MCO Name>> uses a tool called the Long Term Care Functional Screen to check your level of care once a year or whenever your condition changes.

**Your level of care has changed from nursing home level to non-nursing home level**

We checked your level of care on <<Insert determination date>>, and determined that you no longer meet the nursing home level of care but are still eligible for the Family Care program at the non-nursing home level of care.

Effective <<effective date>>, you will have access to the Family Care program’s non-nursing home level of care services. Please see page <<insert page number>> in your Member Handbook for the list of services available to members at the non-nursing home level of care.

**Review of Medicaid eligibility**

The change in your level of care will cause an automatic review of your Medicaid (MA, Title 19) eligibility. This review could result in a change in your eligibility. If you have questions about Medicaid, contact your income maintenance agency at <<Insert Telephone Number>>.

**What to do if you disagree**

If you think the Long Term Care Functional Screen results are wrong, you can ask for a new functional screen. To request a new screen, contact <<Screen Lead Name>>, <<MCO Name>>’s Long Term Care Functional Screen Lead, at <<Insert Telephone Number>>.

If the new functional screen results also determine a non-nursing home level of care or you do not ask for a new functional screen, you have the right to request an appeal. Instructions about how to appeal this decision begin on page three.

We will send you a notice if there will be any change in the services you receive as a result of the change in your level of care. You will have the opportunity to appeal any of those changes.

If your health or condition changes in the future, please contact <<Enter name and phone number of contact>> to ask for a new screen. <<Enter name/title>> will talk with you about any impacts of this change.

**Have questions about this letter?**

If you have questions about this letter, please contact <<Enter name of contacts>> at the numbers listed below.

Care Team

<<Nurse Name>>

<<Nurse Title>>

<<Nurse Phone Number>>

<<SW Name>>

<<SW Title>>

<<SW Phone Number>>

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| **Appeal Rights** |
| 1. **How to appeal this decision**   If you disagree with this decision, write, call, fax or email:  <<MCO Name>>  MCO address  appropriate contact phone number  appropriate fax number  appropriate email address  You can get the Appeal Request form online at [www.dhs.wisconsin.gov/familycare/mcoappeal.htm](http://www.dhs.wisconsin.gov/familycare/mcoappeal.htm), or by calling one of the independent ombudsman agencies listed at the end of this notice.  **Include a copy of this notice with the completed request form or letter.** |
| 1. **Grievance and Appeal Committee**   After <<MCO Name>> receives your request, we will set up a meeting with our Grievance and Appeal Committee. The committee is made up of <<MCO Name>> representatives and at least one person who is also receiving services from us (or represents someone who does).  You have the right to appear in person if you choose. You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony to this committee.  You will receive a written decision on your appeal. If you do not agree with the Grievance and Appeal Committee’s decision, you can request a state fair hearing. See section 6 for more information. |
| 1. **Continuation of services**   If you are getting benefits and you ask for an appeal before your benefits change, you can keep getting the same benefits until the Grievance and Appeal Committee makes a decision on your appeal.  If you want to keep your benefits during your appeal, **your request must be postmarked, faxed, or emailed on or before** **[insert effective date of intended action]**.  If the Grievance and Appeal Committee decides that <<MCO Name>>’s decision was right, you may need to repay the extra benefits that you received between the time you asked for your appeal and the time that the Grievance and Appeal Committee makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost. |
| 1. **Deadline to file your appeal with <<MCO Name>>**   You should file your appeal as soon as possible.  Your appeal to <<MCO Name>> must be postmarked, faxed or emailed **on or before** **insert date that is the mailing date + 60 calendar days** . **Important**: If you would like your benefits to continue during your appeal, your appeal must be postmarked, faxed or emailed **on or before** **insert effective date of intended action.** |
| 1. **Speeding up your appeal with <<MCO Name>>**   You may ask <<MCO Name>> to speed up your appeal. If <<MCO Name>> decides that taking the standard amount of time could seriously harm your health or ability to perform your daily activities, we will grant you a faster appeal called an “expedited appeal.” This means you will receive a decision on your case within 72 hours of your request. If you want to learn more about an expedited appeal, contact <<MCO Name>> at MCO phone number. |
| 1. **State fair hearing**   You have the right to ask for a state fair hearing if you do not agree with the Grievance and Appeal Committee’s decision on your appeal.  If you ask for a state fair hearing, you will have a hearing with an independent Administrative Law Judge (ALJ). You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony at the hearing.  <<MCO Name>>’s member rights specialist can assist you with filing a fair hearing request. To contact a member rights specialist, call Member Rights Specialist phone number. You can also get the hearing form from one of the independent ombudsman agencies listed at the end of this notice or online at [www.dhs.wisconsin.gov/library/f-00236.htm](http://www.dhs.wisconsin.gov/library/f-00236.htm).  Send the completed request form or a letter asking for a hearing and a copy of this notice to:  Family Care Request for Fair Hearing  Wisconsin Division of Hearings and Appeals  PO Box 7875  Madison, WI 53707-7875  Fax: 608-264-9885  **Important Note:** You cannot request a state fair hearing until you have received the Grievance and Appeal Committee’s decision on your appeal or <<MCO Name>> fails to send you a written decision within 30 calendar days of receiving your appeal.  You have 90 calendar days from the date you receive the Grievance and Appeal Committee’s written decision on your appeal to request a state fair hearing. If <<MCO Name>> fails to send you a written decision within 30 calendar days of receiving your appeal, the 90 days starts the day after the 30 calendar day period ends. |
| 1. **Who can help you understand this notice and your rights?**   <<MCO Name>>’s member rights specialist can inform you of your rights, try to informally resolve your concerns, and assist you with filing an appeal. The member rights specialist **cannot** represent you at a meeting with our Grievance and Appeal Committee or at a state fair hearing. To contact a member rights specialist, call MCO phone number.  Anyone receiving Family Care services can get free help from an **independent ombudsman**. The following agencies advocate for Family Care members: |
| **For members age 18 to 59:**  Disability Rights Wisconsin  Toll Free: 800-928-8778  TTY: 711 |
| **For members age 60 and older:**  Wisconsin Board on Aging and Long Term Care  Toll Free: 800-815-0015  TTY: 711 |
| 1. **Copy of your case file**   You have the right to a free copy of the information in your case file related to this decision. Information means all documents, medical records, and other materials related to this decision. If you decide to appeal this decision, you have the right to any new or additional information <<MCO Name>> gathered during your appeal. To request a copy of your case file, contact appropriate contact at phone number. |