pennsylvania
DEPARTMENT OF HUMAN SERVICES

Attachment #3: Letter to ODP waiver participant who has remained in reserved capacity for more than 180 days

DATE

Waiver Participant

Address

Dear [Name of Participant or Surrogate]:

On XX/XX/XXXX (date of initial letter), our office notified you that it would reserve your waiver capacity for up to 180 consecutive days as required by the approved (XX) waiver. The 180 days of reserved capacity was calculated from the first date of your leave from the waiver program as indicated on the PA-162 Notice sent to you from the County Assistance Office. The PA-162 Notice stated that your first day of leave was XX/XX/XXXX. 180 consecutive days from XX/XX/XXXX is XX/XX/XXXX.

Our records indicate that you continue to remain in the hospital, nursing home, or rehabilitative care facility. As a result, your waiver capacity can no longer be reserved. Effective XX/XX/XXXX, your (XX) waiver enrollment will be ended. You should contact your Supports Coordinator to discuss your need for services.

A copy of the Fair Hearing Instructions and Request Form (DP 458) is enclosed for your reference. You may appeal this decision by asking for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be postmarked within 30 days from the date on this notice.

If you have any questions or require assistance filing an appeal, please contact me at (telephone number) or contact your Supports Coordinator.

Sincerely,

Name

Enclosure:

DP 458, "Fair Hearing Request Form"

cc: Individual's File

Individual's Surrogate [if applicable]

Individual's Supports Coordinator

County MH/ID Program or Administrative Entity

Residential Provider [if applicable]