

Adequate Action Notice

An Adequate Action Notice must be sent when the **new applicant** appears to be ineligible for services based on the Michigan Medicaid Nursing Facility Level of Care Determination. It also applies to new applicants who request a LOC Determination, but the MIChoice Program is currently at capacity.

Adequate Action Notice - LOCD	2
Adequate Action Notice - TIG	3
Capacity Adequate Action Notice	4

Rev. per MSA 06-05

(MI Choice Provider Letterhead)
Adverse Action Notice

Adequate Action Notice - LOCD

Date:

Name:

Address:

City, State, Zip code

Dear _____:

Following a review of your long term care needs, it has been determined that you do not qualify for MI Choice Program services based on the Michigan Medicaid Nursing Facility Level of Care Determination. You did not qualify under any of the following eligibility categories: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request all or any of the following:

Immediate Review: To obtain an Immediate Review, you must contact the Michigan Peer Review Organization (MPRO) at 800-727-7223 before 12:00 PM (noon) of the next business day following your receipt of this notice.

Medicaid Fair Hearing: To request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

**Request for Administrative Hearing
Michigan Administrative Hearing System
Michigan Licensing and Regulatory Affairs
PO Box 30763
Lansing, Michigan 48909**

The Medicaid Fair Hearing Request **must** be:

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

Sincerely,
(provider representative)

(MI Choice Provider Letterhead)
Adverse Action Notice

Adequate Action Notice - TIG

(Denial based upon Telephone Intake Guidelines)

Date:

Name:
Address:
City, State, Zip code

Dear _____:

Following a review of your long term care needs, it has been presumed that you would not qualify for MI Choice Program services based on the Telephone Intake Guidelines for the Michigan Medicaid Nursing Facility Level of Care Determination. You do not appear to qualify under any of the following eligibility categories: Activities of Daily Living, Cognition, Physician Involvement, Treatments and Conditions, Skilled Rehabilitative Therapies, Behavior, or Service Dependencies. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request one or both of the following:

In-Person Determination: To obtain an in-person determination, you must contact our agency at (XXX) XXX-XXXX to set up an appointment. We may request that you come to our office to complete this determination.

Medicaid Fair Hearing: To request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

**Request for Administrative Hearing
Michigan Administrative Hearing System
Michigan Licensing and Regulatory Affairs
PO Box 30763
Lansing, Michigan 48909**

The Medicaid Fair Hearing Request **must** be:

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

Sincerely,
(provider representative)

(MI Choice Provider Letterhead)
Adverse Action Notice
Adequate Action Notice

Capacity Adequate Action Notice

Date:

Name:

Address:

City, State, Zip code

Dear _____:

Although you requested an evaluation under the Michigan Medicaid Nursing Facility Level of Care Determination for MI Choice Program services, the MI Choice Program is currently at program capacity, therefore, the waiver agency cannot evaluate you for enrollment at this time. The legal basis for this decision is 42 CFR 440.230 (d).

If you do not agree with this action, you may request the following:

Medicaid Fair Hearing: To request a Medicaid Fair Hearing, complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to:

**Request for Administrative Hearing
Michigan Administrative Hearing System
Michigan Licensing and Regulatory Affairs
PO Box 30763
Lansing, Michigan 48909**

The Medicaid Fair Hearing Request **must** be:

- **Received within 90 calendar days of the date of this notice**
- In writing, and
- Signed by you or a person authorized to sign for you

Sincerely,
(provider representative)