[*Nursing Facility* Letterhead]

Advance Action Notice

Date:
Name:
Address: City, State, Zip code

Dear _____:

This notice is to inform you that a Level of Care Determination (LOCD) conducted on [date], determined that you no longer meet the functional eligibility requirement for Medicaid long-term care services. LOCD functional eligibility will be terminated effective [date: notice date plus 90 days]. Your previously authorized services will continue until the effective date. The legal basis for this decision is 42 CFR 440.230(d). Enclosed you will find a copy of your LOCD.

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

REQUEST A SECONDARY REVIEW: You have a right to request a *Secondary Review* from the iMPROve Health This review will look at the same information we used, as well as other possible needs you may have. To request a Secondary Review, contact iMPROve Health *within 3 (three) business days* following the receipt of this notice at 800-727-7223.

REQUEST AN APPEAL (MEDICAID FAIR HEARING): You have a right to a Medicaid Fair Hearing. You have *90 calendar days* from the date of this notice to request a Medicaid Fair Hearing by mail or fax. The request must be in writing and signed by you or a person authorized to sign for you. 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 Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
PO Box 30763
Lansing, Michigan 48909

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Or fax it to:
FAX NUMBER: 517-763-0146

If you have any questions, you can talk to *< staff person name >* at our facility or call the Michigan Long Term Care Ombudsman Program at 866-485-9393 for help understanding your options.

Sincerely,
<provider representative>

Attachments:
1. LOCD
2. Secondary Review – Exception Process Information Sheet
3. Request for an Administrative Hearing (DCH-0092) form