Appealing an HCBS Level of Care Determination

A Quick Guide for Individuals and Families



Important

If you disagree with a Level of Care denial, request an appeal promptly. You must request an appeal within 33 days of the date on the decision letter. Do not wait to gather all of your evidence before filing.

1 Review the Decision

Read the decision carefully. Identify the Level of Care finding or findings that you believe do not accurately reflect the person's actual functioning and support needs. For FSW and CIH, the letter identifies findings in six functional areas. For H&W and TBI, you may need to obtain and review the Level of Care assessment to understand the basis for the denial.

2 Submit the Appeal

Follow the appeal instructions in the decision letter. Briefly state what finding you disagree with and why. Include a copy of the decision, keep copies of everything you submit, and use a method that confirms when it was sent or received. You may name an authorized representative, such as a family member or advocate, to help with the appeal.

3 Gather Supporting Evidence

Focus on evidence that directly relates to the disputed finding. Useful evidence may include medical or therapy records, evaluations, safety or behavior plans, incident reports, school or employment records, provider documentation, and statements from people with firsthand knowledge of the individual's abilities. Describe what the person can and cannot do, what help is needed, how often it is needed, and why it is needed.

4 Prepare Your Appeal Packet

Read the Notice of Telephone Hearing from the Office of Administrative Law Proceedings (OALP). Follow its deadlines and instructions. A packet must include a copy of the notice and may include a Witness List, List of Exhibits, short Summary of Facts, Position Statement, and supporting exhibits. Organize the packet around the specific finding being challenged.

5 Prepare for & Participate in the Hearing

Be ready to explain: (1) what finding is wrong; (2) why it does not reflect the person's actual functioning and support needs; (3) what evidence supports your position; and (4) what outcome you are requesting. Have your packet and the state's evidence available. Keep testimony accurate, specific, and focused.

Describe Actual Support Needs

Be accurate and truthful. Do not exaggerate needs, but do not minimize them. Explain if the person ordinarily needs prompting or directives, supervision, physical assistance, adaptive equipment, extra time, or other support.

Continuing Services During an Appeal

If a person already receives waiver services and submits a timely appeal request for a waiver re-eligibility determination, DDARS has advised that waiver services and associated Medicaid will remain active during the appeal, with no repayment if the denial is ultimately upheld. This includes administrative and judicial appeals, though different rules may apply to Medicaid financial eligibility appeals.

Need Help? The Arc of Indiana's Advocacy Network may provide general information, guidance, and advocacy support. You may also use an authorized representative or consult an attorney. Free or reduced-cost legal assistance may be available depending on eligibility and capacity. **317.977.2375** **arcind.org**

This quick guide is for general informational and educational purposes. It is not legal advice.
Always review your own decision, appeal notice, and deadlines. See the Detailed Guide for additional information.

The Arc Indiana