SAMPLE NOT-AUTHORIZED LETTER FROM THE MEDICAID LTSS SCREENING

FOR THE COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) WAIVER OR PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) OR NURSING FACILITY SERVICES

DATE

Mrs. Mary Jones
0000 Avenue
Home Town, Virginia 00000

Dear Mrs. Jones:

Purpose of this letter:

This letter is being sent to you in response to your recent screening for Medicaid-funded long term services and supports (LTSS). These services may include home and community based services or nursing facility care. Home and community based services include the options of: the Commonwealth Coordinated Care Plus (CCC Plus) Waiver or the Program of All Inclusive Care for the Elderly (PACE) program. The Virginia Department of Medical Assistance Services (DMAS) requires that an individual seeking LTSS be screened to determine if they meet the level of care criteria for services provided in a LTSS setting. In a separate process, individuals must also be screened to determine financial eligibility for Medicaid.

What this screening means for you:

The screening team, in accordance with Medicaid regulations, policy and procedures, with your input, have determined that you do not meet the level of care criteria for Medicaid funded LTSS because **[Screener** - ***Insert the specific reason(s) why the individual does not meet the criteria and add: 42 C.F.R. § 431.210, 12 VAC 30-60-303. Please be as specific as possible and make citations to Medicaid LTSS Screening Manual and regulations].***

This determination is based on the screening team's assessment of your functional abilities, medical and nursing needs, and overall risk of requiring institutional care.

[Screener - When a referral is made to any community agencies/resources, insert this information here. If you indicate a provider or community resource will make contact with the individual you must provide the individual's contact information to the referral agency in order to assure the referral can be addressed.]

[Screener - When a referral is made to the Community Services Board or other community agencies/resources for active treatment, insert the paragraph below as follows:]

Your service needs:

It has been determined that you are in need of active treatment for a condition of Mental Illness, a Developmental Disability or related condition. This determination is based on the assessment of your functional abilities, medical needs, psychological needs, and need for active treatment. A member of the local Community Services Board (CSB) or other community agencies/resources will be in contact with you to arrange for active treatment services. (*LTSS Screeners are responsible for making the referral to the CSB or other community agencies. You must provide the individual's contact information to assure the referral can be addressed.)*

You have the right to appeal this decision:

If you do not agree with the decision provided in this letter, you may ask to have an impartial representative review your request for services. This is called an appeal (42 CFR §431.200 *et seq*., 12 VAC 30-110-10 through 370).

Ways to ask for an appeal with DMAS:

1. **Electronically.** Online at www.dmas.virginia.gov/#/appealsresources or email to appeals@dmas.virginia.gov
2. **By FAX. FAX** your appeal request to DMAS at (804) 452-5454.
3. **By mail or in person.** Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
4. **By phone.** Call DMAS at (804) 371-8488 (TTY: 1-800-828-1120)

To help you, an appeal request form is available from DMAS at **www.dmas.virginia.gov/#/appealsresources**. You can also write your own letter. Include a full copy of your final denial letter when you file your appeal with DMAS. Also, include any documents you would like DMAS to review during your appeal. **Your deadline to ask for an appeal with DMAS is 35 days from the date on this letter.**

If you choose to appeal, you may represent yourself, consult and be represented by legal counsel, or bring a friend, relative or other spokesperson to speak on your behalf at the appeals hearing.

DMAS will make a decision on your appeal within 90 days of your request.

It has been our pleasure to work with you. If you have any questions regarding this LTSS screening, feel free to call us at **[Insert phone number here]**.

Sincerely,

(Name/Title of a LTSS Screening Team Member)
Medicaid LTSS Screening Team
(Name of Agency, Hospital or Nursing Facility)

pc: