Ohio Department of Aging

NOTICE OF PROPOSED ACTION - RIGHT TO A STATE HEARING

Name		
Street Address	Client Identification Number	Program
City, State, and Zip Code	County	Mailing Date

The Ohio Department of Aging is proposing to take the following action(s) on your state-funded program.

☐ Your request for enrollment into the state funded ______________________________________ program has been denied.

☐ You will have to pay a monthly patient liability in the amount of $__________________________;

effective___________________; which should be paid to________________________________.

☐ There will be a change in the service(s) that you receive; specifically________________________

____.

This change is effective____________________________.

☐ We are proposing to disenroll you from the state-funded _______________________________

program effective _____________________. Your last date of service will be_______________.

If you disagree with this proposed action(s) and submit a written request for an appeal hearing to The Ohio Department of Aging within thirty days of the mailing date of this notice; no later than: ____ ____________________ then the action(s) will not be taken until the state hearing is decided, or the statutory three-month limit on your receipt of state-funded services is met, whichever occurs first.

Reason for, and the regulations supporting, the proposed action(s) are as follows: The reasons for this proposed action are: The rules that require this action are:

YOU MAY APPEAL THIS ACTION; HOWEVER, **IN ORDER TO PERFECT AN APPEAL, BOTH PAGES OF THIS FORM MUST BE INCLUDED WITH YOUR REQUEST FOR AN APPEAL**.

If you do not understand this proposed action or want to talk to your case manager about it, please call:

Case manager:	Telephone Number:

 Please Continue Reading the Back/Next Page Form ODA Form 1117 (rev Jan. 2012)

Your Right to a State Hearing:

The purpose of this notice is to tell you about the action we are planning to take on your case. If you do not understand this action, you should contact your case manager. After discussing the reasons for this action with your case manager, it is possible that we will change our decision or that you will agree with the action.

If you do not agree with this action, you have a right to a state hearing:

A state hearing lets you or your representative (lawyer, welfare rights worker, friend or relative) give your reasons against proposed action. If you wish, you may subpoena witnesses to appear at the hearing, and you may present evidence and examine any witnesses appearing for or against you at the hearing. We will also attend or be represented at the hearing to present our reasons for the proposed action. An independent hearing officer retained by the Ohio Department of Aging will decide who is right. If you prefer, you may submit a written statement of your reasons why the proposed action is inappropriate instead of making these arguments in person at the scheduled hearing

If you want a hearing, we must receive your written hearing request within 30 days of the mailing date of this notice. Your request for a hearing must include both pages of this form. **You do not need to return this form if you agree with the proposed action.**

If someone else makes a written hearing request for you, the hearing request must include a written statement, signed by you, telling us that that person is your representative. No hearing requests will be accepted over the telephone.

If you lose your hearing, you may have to pay back any benefits that you were given but were not eligible to receive.

If you want information on free legal services, but don't know the number to your local legal aid office, you can call the Ohio State Legal Services Association for the local number, toll free, at 1-800-589-5888.

If you want a hearing, you must sign your name below, and send this form to:
Director, The Ohio Department of Aging, 50 W. Broad Street, 9th Floor, Columbus, Ohio 43215.

IN ORDER TO PERFECT AN APPEAL, BOTH PAGES OF THIS FORM MUST BE INCLUDED WITH YOUR REQUEST FOR AN APPEAL.

Signature:	Date:	Telephone Number: ( )