

**Ohio Department of Aging
NOTICE OF PROPOSED CHANGE IN BENEFITS**

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

The Ohio Department of Aging is proposing to change the amount of client/patient liability that you are required to pay as a condition to your receipt of services through the state-funded _____ program. If you disagree with this proposal, you are entitled to a state hearing, so long as your written request for a hearing is received by the Department within thirty days of the mailing date of this notice.

Reason for, and Regulations Supporting, this Proposed Action:

The reasons for this proposed action are:

The rules that require this action are:

If you do not understand the reasons for the Department's proposal, or if you want to talk to your case manager about it, please call:

Case manager:	Telephone Number:
---------------	-------------------

Please Continue Reading the Back of this Page

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 the 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 proposing to increase the amount of your client liability. 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 for believing that the proposed increase is inappropriate instead of making these arguments in person at the scheduled hearing

If we receive your written request for a hearing by _____, the proposed action will not be taken until the state hearing is decided. If you lose your hearing, you may have to pay any amount of the client/patient liability amount that you did not pay while a decision in your case was pending.

If someone else makes a written request for a hearing on your behalf, the hearing request must include a written statement, signed by you, telling us that that person is your representative.

No hearing request will be accepted over the telephone.

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, Ohio Department of Aging, 50 W. Broad Street, 9th Floor, Columbus, Ohio 43215.

Signature:	Date:	Telephone Number: ()
------------	-------	------------------------------