

**NOTICE OF AGENCY ACTION**

Services funded by **MEDICAID WAIVER**: Applicant/Recipient is entitled to a **FORMAL HEARING** with the Department of Health, Division of Health Care Finance.

Mailing Date \_\_\_\_\_ Agency File No. \_\_\_\_\_  
Applicant: \_\_\_\_\_  
Legal Guardian (if any): \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Dear \_\_\_\_\_ :

In accordance with the Utah Administrative Procedures Act (Title 63, Chapter 46b of the Utah Code) and the rules of the Utah Department of Human Services, the Division of Services for People with Disabilities (the "Division") hereby gives notice that it is taking the following action with respect to your application or the services you receive:

- Approve
- Deny
- Increase
- Reduce
- Place on Waiting List
- Other (*specify*):

This action is based upon the following facts:

Title 62A, Chapter 5 of the Utah Code authorize this action and give the Division jurisdiction.

You have the right to appeal this decision as per R539-3-7. Under Rule R410-14-5 of the administrative hearing procedures for the Department of Health, you may request a formal hearing if you file your request on time and if there is a disputed issue of fact. Formal hearings are governed by Sections 63-46b-6 to -11 of the Utah Code. If you need help in preparing your appeal, you may call our office at (\_\_\_\_\_) - \_\_\_\_.

You do not have to appeal if you do not want to. If you wish to appeal, however, you must send us a written hearing request within 30 days of the postmark date for this notice. If you wish your services or benefits to continue during the resolution/hearing process, your hearing request must be filed within 10 days of the postmark of this notice. If your request is not received within 15 days, you will not be eligible for continued benefits. If you fail to file a hearing request or to attend a scheduled hearing, you may lose your right to challenge the agency action or you may be held in default.

If this notice indicates above that you are eligible to receive Medicaid waiver support services, you are also eligible to receive services in an Intermediate Care Facility for People with Mental Retardation (ICF/MR). Please contact your support coordinator for more information.

Sincerely,

Name	Title	cc:
Signature	Date	

**Instructions for completing Form 522-F**

1. Type in the date this form was mailed to the applicant/recipient.
2. Type in the agency's file number.
3. Type in the name of the applicant/recipient.
4. Type in the name of legal guardian, if any.
5. Type in the complete address for the applicant/recipient and legal guardian, if applicable.
6. Indicate (by checking a box or typing) the type of action referenced in this Notice of Agency Action Form.
7. Type in the relevant facts.
8. Cite the policy and standards covering the agency action.
9. Type in your name and title.
10. Type in the name(s) of the Person(s) to be sent copies of the Notice of Agency Action Form.
11. Sign and date the document.