STATE OF MONTANA
Department of Public Health and Human Services

HCBS SDMI 599-1

SCREENING DETERMINATION

_____ Name of Applicant _____ Street Address _____ _____ City and Zip Code Social Security No.	Mountain Pacific Quality Health 3404 Cooney Drive Helena, MT 59602 Phone: 1-800-219-7035/406-443-0320 Fax: 1-800-413-3890/406-443-4585

SCREENING DETERMINATION:

On _____ you were screened to determine if you are in need of Long Term Care Services. Long Term Care Services include nursing facility care and the Home and Community Based Services program. The decision of the screening professional is:

☐ Long Term Care Services **ARE NOT** required and will **NOT** be paid by Medicaid. If Medicaid payment is currently being made for Long Term Care Services, it will terminate on _____. You may be eligible for other Medicaid Services. Contact your local Office of Public Assistance for further information.

☐ Long Term Care Services **ARE** required and Medicaid **WILL** pay **IF YOU ARE FINANCIALLY ELIGIBLE**. Contact your local Office of Public Assistance regarding financial eligibility. For Home and Community Based Services, Medicaid payment is dependent upon the availability of a slot.

☐ A temporary placement has been approved for Long Term Care Services. This approval expires on _____. You will be rescreened before the expiration date.

If you have not entered Long Term Care Services (Nursing Facility or Home and Community Based Services) and determined financially eligible within 60 days of the screening date, this screening determination is no longer valid.

RECIPIENT'S CHOICE OF LONG TERM CARE PROGRAM: Nursing Facility ☐ Home & Community Based Services ☐	Effective Date: _____ **(See second page for further explanation of effective date.)**

If you are financially eligible for Long Term Care Services, you may choose to apply for services in a nursing facility or through the Home and Community Based Services Program. If you have any questions regarding this action or if you have additional facts to present, please write or telephone the Mountain Pacific Quality Health Foundation (address, phone above).

Reviewer: _____ Name Date _____	LEGAL BASIS for ACTION: **LONG TERM CARE** ARM 37.40.101, 105, 106, 110, 120, 201, 202, 205, 206 42 CFR ∋456.360, 370, 371, 372, 431-438; 42 CFR ∋483.12 Part 483 Subparts C and E

REQUEST FOR FAIR HEARING

IF YOU DISAGREE WITH THIS DETERMINATION, YOU MAY REQUEST A FAIR HEARING. PLEASE READ THE SECOND PAGE OF THIS NOTICE FOR FURTHER INFORMATION ON THE FAIR HEARING PROCESS.

I request a fair hearing for these reasons: _____

_____

_____

_____

_____

_____

_____

I have an attorney: ☐ YES ☐ NO

My attorney's name is: _____

Attorney's address: _____

Attorney's phone number: _____

_____ _____ _____
(Claimant or Authorized Representative) (Phone) (Date)

To request a fair hearing complete, sign and mail the white copy of this notice to: Hearing Officer, P.O. Box 202953, Helena, MT 59620.

cc: County _____ cc: Provider _____

Benefits and services must be provided without regard to race, color, national origin, religion, political belief, age, disability, sex or marital status.

If you feel that you have been discriminated against, you may contact the Department of Public Health and Human Services for information on how to file a complaint.

IMPORTANT

If you disagree with the determination stated on this form you may request a fair hearing before a hearing officer of the Board of Public Assistance.

Under certain circumstances you may continue to receive services during the period of your appeal. A request for continuation of services must be made prior to the date given in the notice of the change in or termination of your services. If you are interested in continuing to receive services during the period of your appeal, you must contact one of the regional offices immediately to request continuation of services. If you lose your appeal, you will be fiscally responsible for services delivered during the appeal process.

A request for fair hearing must be made in writing within 90 days of the mailing date of this notice. You may use the "Request for Fair Hearing" section on the front section of this form to make your request. A request for fair hearing must be directed to:

Hearings Officer
P.O. Box 202953
Helena, MT 59620

If you need assistance in preparing a request for fair hearing you may contact one of the regional offices listed below.

Prior to the fair hearing, a program officer for the Department will conduct an administrative review of the matters which you are appealing. The administrative review is an opportunity for you to informally present your case and for the Department to reconsider the matters that you are appealing.

The fair hearing is a process in which the parties formally present their legal arguments and evidence in support of their positions on the matters at issue. The decision of the hearing officer is made based on the evidence presented at hearing and upon the governing federal and state laws, regulations and policies. The decision of the hearing officer may be appealed to the Board of Public Assistance. The Board of Public Assistance reviews the matters at issue as presented before the hearing officer. This appeal does not involve another hearing. The decision of the hearing officer or the Board of Public Assistance resolves the matters at issue and is binding upon the parties unless an appeal is made to state district court.

COMMUNITY PROGRAM OFFICERS

Community Program Officer 2121 Rosebud Dr., Ste D17 Billings, MT 59102 Phone: 655-7622	Big Horn, Carbon, Stillwater, Yellowstone, Sweet Grass
Community Program Officer 305 Mercury St, Room 401 Butte, MT 59715 Phone: 496-4989	Beaverhead, Deer Lodge, Granite, Silver Bow, Powell, Jefferson , Gallatin, Park, Madison, Broadwater
Community Program Officer 201 1st St S, Ste. 3, Room 165 Great Falls, MT 59405 Phone: 454-6078	Blaine, Cascade, Choteau, Liberty, Glacier, Hill, Pondera, Toole, Teton, Phillips, Northern Jefferson, Lewis and Clark
Community Program Officer Lake 2685 Palmer, STE G Missoula, MT 59808 Phone: 329-1610	Missoula, Ravalli, Flathead, Sanders, Lincoln

EXPLANATION OF EFFECTIVE DATE

Nursing Facilities:
The local Office of Public Assistance will determine date of financial eligibility. Actual effective date for Medicaid reimbursement for nursing facility services will be the later of these two dates: 1) effective date listed on the front; or 2) the date of financial eligibility.

Home and Community Based Services:
If you are on a waiting list for Home and Community Based Services, enrollment will be dependent upon the availability of slots. If enrollment is more than 90 days from the screening date listed on the front, a new screen is required.