STATE OF MONTANA
Department of Public Health and Human Services

BIG SKY WAIVER
TERMINATION OR DENIAL OF PROGRAM COVERAGE

Section 1: Member Information

Name:____

Address:____

Section 2: CMT Information

Name:____

Address:____

Phone Number:_______________________________________

Section 3: Termination of Program Coverage

Your coverage under the Big Sky Waiver Program is being terminated effective _________________ due to:

- ☐ Member's plan of care exceeds allowable limits.
- ☐ The services are no longer appropriate or effective in relation to the member's needs.
- ☐ Member's failure to use services as provided for in the service plan.
- ☐ Member's behavior creates serious risk to the member, caregivers or others or substantially impede the delivery of services as provided for in the service plan.
- ☐ The health of the member is deteriorating or in some other manner placing the member at serious risk of harm.
- ☐ The service providers necessary to the delivery of services are unavailable.
- ☐ The services requested by the member do not prevent institutionalization;
- ☐ Insufficient Big Sky Waiver program funds.
- ☐ Member's needs cannot be met through the Big Sky Waiver program.
- ☐ Member's refusal to sign the service plan.
- ☐ Medicaid ineligibility.
- ☐ CSB received notification from OPA confirming Medicaid ineligibility.
- ☐ Member moved out of state*.
- ☐ Member transitioned to another Medicaid program*.
- ☐ The member is admitted to a nursing facility, hospital or Transitional Care

Unit (TCU) for a stay expected to/has exceeded 30 days*.

- ☐ Member's written request to end program coverage*.
- ☐ Member's death*.
- ☐ Other.

*Does not require RPO Authorization

Section 4: Denial of Program Coverage

Your request for coverage under the Big Sky Waiver Program is denied due to:

- ☐ The service providers necessary to the delivery of services are unavailable.
- ☐ The services requested by the member do not prevent institutionalization.
- ☐ Member is not 65 years of age older*.
- ☐ Member has not been certified as disabled by the Social Security Administration or the Medicaid Eligibility Determination services*.
- ☐ Insufficient Big Sky Waiver program funds.
- ☐ Member's needs cannot be met through the Big Sky Waiver program.
- ☐ Medicaid ineligibility.
- ☐ Member moved out of state*,
- ☐ Member transitioned to another Medicaid program*.
- ☐ The member is admitted to a nursing facility, hospital or Transitional Care Unit (TCU) for a stay expected to/has exceeded 30 days *.
- ☐ Member's written request to withdraw program request*.
- ☐ Member's death*.
- ☐ Other.

*Does not require RPO Authorization

Section 5: CMT Authorization

Case Management Team Signature:

____

Date:________________________

Section 6: RPO Authorization

BIG SKY WAIVER
TERMINATION OR DENIAL OF PROGRAM COVERAGE

Regional Program Officer Signature:

____

Date:______________________

Legal Basis for Action:

ARM 37.40.1401, .1426; ARM 37.5.307; 42 CFR Part 431 Subpart E; Big Sky Waiver Application.

IMPORTANT

If you disagree with the determination stated on this front of this form, you may request a fair hearing before an Administrative Law Judge of the Office of Fair Hearings. You must request a fair hearing in writing or complete information below, sign and mail to address listed below.

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 indicate in your request for a fair hearing. Benefits provided to a claimant pending a hearing decision are subject to repayment by the claimant if the adverse action is sustained.

A request for a hearing by a claimant must be received by the department within 90 days from the date of mailing of notice of the adverse action. You may use the “Request for Fair Hearing” section below to make your request. A request for fair hearing must be directed to: Department of Public Health and Human Services Office of Fair Hearing, PO Box 202953, Helena, MT 59620.

REQUEST FOR FAIR HEARING

I am requesting a continuation of benefits during the period of the appeal if eligible:

☐ YES ☐ NO

I request a fair hearing for the following reasons:

____

____

I have an attorney:

☐ YES ☐ NO

My attorney's contact information:

Name:____

Address:____

Phone number:_______________________________________

Claimant or Authorized Representative Signature:

____

Phone:____

Date:_______________________

Prior to the fair hearing, a Department representative will conduct an administrative review of the matters which you are appealing. The administrative review is an opportunity 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 Administrative Law Judge is made based on the evidence presented at the hearing and upon governing federal and state laws, regulations and policies. The decision of the Administrative Law Judge resolves the matters at issue and is binding upon the parties unless an appeal is made to state district court.