Division of Disability and Rehabilitative Services
Bureau of Developmental Disabilities Services

Service Authorization/Notice of Action

See the last page of this form for important information about your responsibilities and appeal rights.

Mailing date of authorization/notice of action 01/12/2023

Funding Program: Family Supports Waiver

Name:
Date of Birth:
Address:

Medicaid Number:
Medicaid Eligibility Date: 02/01/2016
Waiver Start Date: 04/04/2017

PCISP Identification

PCISP Serial Number: 000
PCISP Start Date: 03/01/2023
PCISP Status: Authorized
Level of Care: Intermediate Care Facility/Intellectual Disability

PCISP Type: Annual
PCISP End Date: 02/29/2024
Decision Date: 01/12/2023

Reason for Decision

Authorization of the PCISP
Reason for the Authorization: Meets eligibility criteria to receive Medicaid services authorized by 42 CFR 441.300 Subpart G and the authorized Persons with Development Disabilities Waiver request. Services Auto-Authorized

Description of Change Section

This authorization for waiver services only ensures payment when, prior to the delivery of any service, the provider verifies that this individual has the correct type of open Medicaid (MA) and has not been placed into a Risk-based Managed Care or Hoosier Care Connect. This does not include the Care Select Program. Risk-based Managed Care and Hoosier Care Connect members are not eligible for Home and Community based Waiver Services, but those who receive care through the Care Select Program may be approved for waiver services.

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals.

CONNECTIONS CASE MANAGEMENT, LLC, 9165 Otis Avenue, Suite # 217; (CMGT) - Case Management

CMGT-Case Management

Billing Code	Mod #1	#2	#3	#4	Start Date	End Date	Unit Size	Unit Rate	Current Units	Current Cost
T2022	U7	U5			03/01/2023	03/31/2023	1.00	143.75	1	143.75
T2022	U7	U5			04/01/2023	04/30/2023	1.00	143.75	1	143.75
T2022	U7	U5			05/01/2023	05/31/2023	1.00	143.75	1	143.75
T2022	U7	U5			06/01/2023	06/30/2023	1.00	143.75	1	143.75
T2022	U7	U5			07/01/2023	07/31/2023	1.00	143.75	1	143.75
T2022	U7	U5			08/01/2023	08/31/2023	1.00	143.75	1	143.75
T2022	U7	U5			09/01/2023	09/30/2023	1.00	143.75	1	143.75
T2022	U7	U5			10/01/2023	10/31/2023	1.00	143.75	1	143.75
T2022	U7	U5			11/01/2023	11/30/2023	1.00	143.75	1	143.75
T2022	U7	U5			12/01/2023	12/31/2023	1.00	143.75	1	143.75
T2022	U7	U5			01/01/2024	01/31/2024	1.00	143.75	1	143.75
T2022	U7	U5			02/01/2024	02/29/2024	1.00	143.75	1	143.75

ASSISTED INDEPENDENCE LLC, 2225 Central Ave, Suite 3; (DHI) - Day Habilitation,Individual

DHI-Day Habilitation,Individual

Billing Code	Mod #1	#2	#3	#4	Start Date	End Date	Unit Size	Unit Rate	Current Units	Current Cost
T2020	U7	U5			03/01/2023	03/31/2023	1.00	28.33	35	991.55
T2020	U7	U5			04/01/2023	04/30/2023	1.00	28.33	35	991.55
T2020	U7	U5			05/01/2023	05/31/2023	1.00	28.33	35	991.55
T2020	U7	U5			06/01/2023	06/30/2023	1.00	28.33	35	991.55
T2020	U7	U5			07/01/2023	07/31/2023	1.00	28.33	34	963.22
T2020	U7	U5			08/01/2023	08/31/2023	1.00	28.33	34	963.22
T2020	U7	U5			09/01/2023	09/30/2023	1.00	28.33	34	963.22
T2020	U7	U5			10/01/2023	10/31/2023	1.00	28.33	34	963.22
T2020	U7	U5			11/01/2023	11/30/2023	1.00	28.33	34	963.22
T2020	U7	U5			12/01/2023	12/31/2023	1.00	28.33	34	963.22
T2020	U7	U5			01/01/2024	01/31/2024	1.00	28.33	34	963.22
T2020	U7	U5			02/01/2024	02/29/2024	1.00	28.33	34	963.22

ASSISTED INDEPENDENCE LLC, 2225 Central Ave, Suite 3; (RETH) - Recreational Therapy

RETH-Recreational Therapy

Billing Code	Mod #1	#2	#3	#4	Start Date	End Date	Unit Size	Unit Rate	Current Units	Current Cost
H2032	U7	U5	U2		03/01/2023	02/29/2024	0.25	10.78	576	6209.28

Signature of FSSA Representative: Holly J Humowiec Date: 01/12/2023

Case Management Organization 9-digit authorization: 00

Case Manager: Phone: Email:

The Case Manager should send this form to the individual and legal representative (if applicable). The system will automate sending this form to all active providers.

Notice: See the last two pages of this form for important information about your responsibilities and right to appeal.

Your Appeal Right as an Applicant for HCBS Benefits

If you question the indicated decision, you should discuss this matter with your Case Manager.

Your right to Appeal and Have a Fair Hearing:

The Service Authorization/Notice of Action provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a Fair Hearing. Your Home and Community Based Service (HCBS) benefits will continue if your appeal is received within the required time frame described below under "How to Request an Appeal". If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid on your behalf pending the release of the appeal hearing decision.

How to Request an Appeal:

1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:
(1) 33 calendar days following the effective date of the action being appealed; or
(2) 33 calendar days from the date of the notice of agency action, whichever is later

To file an appeal, please sign, date and return the FSSA Appeals copy of this form to:

Indiana Family and Social Services Administration
Office of Hearings and Appeals
MS 04
402 W. Washington St., E034
Indianapolis, IN 46204

Or Via facsimile to 317-232-4412

If you are unable to sign, date, and return this form to the above-mentioned address, you may have someone assist you in requesting the appeal.

2) Your appeal will be forwarded to the Indiana Office of Administrative Law Proceedings (OALP) to schedule a fair hearing with an Administrative Law Judge with OALP. You will be notified in writing by the office of the date, time, and location for your hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

3) You may represent yourself at the hearing or you may authorize a person to represent you, such as attorney, relative, or another spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference, or refuse any testimony or evidence presented.

I wish to appeal the above decision, for the following reasons: _____

_____

_____

_____

_____

_____

Signature of the Applicant/Guardian: _____

Date Signed: _____

FSSA APPEALS COPY

Your Appeal Right as an Applicant for HCBS Benefits

If you question the indicated decision, you should discuss this matter with your Case Manager.

The Service Authorization/Notice of Action provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a Fair Hearing. Your Home and Community Based Service (HCBS) benefits will continue if your appeal is received within the required time frame described below under "How to Request an Appeal". If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid on your behalf pending the release of the appeal hearing decision.

How to Request an Appeal:

1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:
(1) 33 calendar days following the effective date of the action being appealed; or
(2) 33 calendar days from the date of the notice of agency action, whichever is later

To file an appeal, please sign, date and return the FSSA Appeals copy of this form to:

Indiana Family and Social Services Administration
Office of Hearings and Appeals
MS 04
402 W. Washington St., E034
Indianapolis, IN 46204

Or Via facsimile to 317-232-4412

If you are unable to sign, date, and return this form to the above-mentioned address, you may have someone assist you in requesting the appeal.

2) Your appeal will be forwarded to the Indiana Office of Administrative Law Proceedings (OALP) to schedule a fair hearing with an Administrative Law Judge with OALP. You will be notified in writing by the office of the date, time, and location for your hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

3) You may represent yourself at the hearing or you may authorize a person to represent you, such as attorney, relative, or another spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference, or refuse any testimony or evidence presented.

I wish to appeal the above decision, for the following reasons: _____

_____

_____

_____

_____

_____

Signature of the Applicant/Guardian: _____

Date Signed: _____

APPLICANT COPY