



Letter Date

DLN

CLIENT NAME
[CARE OF PARENT NAME (IF CLIENT IS CHILD)]
MAILING ADDRESS
CITY, STATE, ZIP

Subject: You aren't eligible for the Community Living Assistance and Support Services program.

Dear [Client Name]:

Medicaid Number:

The Health and Human Services Commission (HHSC) has determined that you aren't eligible for the Community Living Assistance and Support Services (CLASS) program for the reason(s) below:

[Reason(s) – Free form text]

You may appeal this decision.

- If you want to appeal this decision, your Case Management Agency (CMA) can help you request a fair hearing.
- You can check the "Request for Appeal" box at the bottom of this letter, sign your name, enter the date and return this notice to your CMA at [insert CMA mailing address]. You may also make this request in person at [insert CMA physical address] or by phone at [insert CMA phone number].
- HHSC must get your request for a fair hearing on or before [Date + 90 calendar days from letter sent date]. If HHSC doesn't get your request by that date, you may lose the right to appeal this decision.
- If you ask for a fair hearing, you may represent yourself. You may also choose a relative, friend, lawyer or other person to act on your behalf. You

[Name]

[Date]

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may have to pay for the person to represent you. To find out if there is free legal help in your area, call 2-1-1.

Rules HHSC used to make this decision:

- [TAC Rule Number] [TAC plain language summary]
 - [Actual TAC language]

If you have any questions, please call HHSC at 512-438-2484.

REQUEST FOR APPEAL

I file this as my appeal and want a fair hearing before an HHSC hearings officer.

Signature – Applicant/Legally Authorized Representative Date

cc: <<LAR (if applicable)>>