**Letter Date**

**DLN**

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

**Subject:** Termination of Services in the Community Living Assistance and Support Services Program, without Advance Notice

Dear [Client Name]:

**Medicaid Number:**

The Health and Human Services Commission (HHSC) will end your Community Living Assistance and Support Services (CLASS) program services on [effective termination date] 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 can also make this request in person at [insert CMA physical address] or by phone at [insert CMA phone number].
- If you don't ask for a fair hearing on or before [Date + 90 calendar days from letter sent date], you may lose the right to appeal this decision.
- If you ask for a fair hearing, you can represent yourself. You can also choose a relative, friend, lawyer or other person to act on your behalf. You 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)>>