NOTICE OF PROPOSED ACTION

DS 1803 (Rev. 1/2007)

Date:

Name of Service Applicant/Recipient:	Medicaid Home and Community Based Services Waiver Participant? *(Check one)* ☐ Yes ☐ No
Address:	Telephone Number:
Name of Authorized Representative:	
Address:	Telephone Number:
Name of Regional Center or State Developmental Center:	

_____ hereby notifies you that it proposes to take the
(Regional Center or State Developmental Center)

following action which may affect your services:

Proposed action:

Reason for action:

Effective date:

Authority for the action (law, regulation, and/or policy in support of the action):

RIGHT TO APPEAL

- You may file an appeal with the Department of Developmental Services on the enclosed Fair Hearing Request form. The regional center or state developmental center is available to assist you in completing the form, if necessary. Submit the completed Fair Hearing Request form to:

- Advocacy assistance with your appeal may be obtained from the following organizations:

  Local Client's Rights Advocate:

  Local Area Board:

  Protection and Advocacy, Inc.:

  Other:

- **YOUR SERVICES WILL CONTINUE DURING THE APPEAL PROCESS IF YOUR REQUEST FOR A FAIR HEARING IS POSTMARKED OR RECEIVED BY THE REGIONAL CENTER OR STATE DEVELOPMENTAL CENTER, WHICHEVER IS EARLIER, NO LATER THAN 10 DAYS AFTER RECEIVING THIS NOTICE.**

  The enclosed brochure, entitled "The Fair Hearing Process for Consumers Age 3 Years or Older", specifies your appeal rights and provides information about the fair hearing process.