October 14, 2010

NOTICE OF
COST PLAN REBASING

I. YOUR COST PLAN WILL BE ADJUSTED ("REBASED")

The Agency for Persons with Disabilities (Agency or APD) is required by law, Section 393.0661(6), Florida Statutes, to adjust cost plans for individuals receiving Medicaid waiver services -- a process referred to as rebasing. As a result, your cost plan will change.

This change is being made because your calculated paid claims for approved services for the 2008–2009 fiscal year plus five percent were less than your current annualized cost plan. The rebased amount is calculated as follows:

A	Current cost plan (annualized for 12 months)	$
B	Calculated paid claims for approved services	$
C	**New annualized allocated amount for approved services (Row B plus 5%)**	**$**
D	Average monthly reduction	$

Row C is the annual amount authorized for approved services after rebasing and will result in an average monthly reduction as shown in Row D. **This change will take effect on November 1, 2010 and continues into future years as applicable.**

You may have received a previous notice of rebasing. If so, that notice no longer applies. This is a new notice that requires you to request a hearing if you disagree with, and wish to challenge, this rebasing decision.

II. CHALLENGING THE REBASING DECISION

You have **30 days** from the date you receive this notice to file a request for hearing. **You have 10 days from the date you receive this notice to file a request for hearing if you wish to continue your cost plan, including future cost plans, at the current approved amounts.** The attached Notice of Hearing Rights provides instructions on how to file a hearing request. Please refer to the attached Hearing Request Form to request a hearing to challenge this rebasing decision.

If you request a hearing within 10 days of the date you receive this notice, your cost plan and future cost plans will be maintained at the current level until your challenge is resolved. **HOWEVER, if your challenge is denied or dismissed, the Agency will seek to recover the amounts paid in excess of your rebased amount.**

If you requested a hearing challenging a prior rebasing notice, that request does **not** apply to this notice. **You must file a challenge to this notice if you disagree with this rebasing decision.**

III. CONTACT YOUR WAIVER SUPPORT COORDINATOR

Your cost plan must be adjusted to comply with the rebased amount, even if you have a pending fair hearing on a different issue such as, including but not limited to, a tier assignment. Contact your Waiver Support Coordinator immediately to discuss this change and how it effects your cost plan. Your Waiver Support Coordinator can assist you in adjusting your services to comply with the statutory requirements.

The Agency for Persons with Disabilities is committed to protecting your health and safety. Additional information about rebasing can be found on the Agency's website at http://apd.myflorida.com. You may contact the local Area APD office if you have questions or need assistance in contacting your Waiver Support coordinator or in completing a hearing request after meeting with your Wavier Support Coordinator.

Notice of Hearing Rights

The Florida Legislature requires the Agency for Persons with Disabilities (APD), to rebase (adjust) cost plans as described in Section 393.0661(6), Florida Statutes.

If you believe that the APD's adjustment of your cost plans is wrong, you may be entitled to an administrative hearing as provided in Sections 120.569 and 120.57, Florida Statutes or 42 CFR 431.220.

If APD determines you have a right to hearing, you may represent yourself or use legal counsel, a relative, a friend, or other spokesperson in a hearing on this matter. If you are not representing yourself, proof of guardianship or other written proof of your representative's authority to act on your behalf is required with the request for hearing.

Section 393.125(1)(d), Florida Statutes, states that you must make your hearing request to the agency, in writing, within thirty (30) days of the date you receive this notice. The request must be signed by you or your authorized representative. You may contact your local APD office if you have questions or need assistance in completing a hearing request.

If you request a hearing within 10 days of the date you receive this notice, your cost plan and future cost plans will be maintained at the current level until your challenge is resolved. **HOWEVER, if your challenge is denied or dismissed, the Agency will seek to recover the amounts paid in excess of your rebased amount.**

The Cost Plan Rebasing Hearing Request Form, included with this notice and also available from your Waiver Support Coordinator, the area office or our website, may be used when requesting a hearing on your cost plan rebasing. If you do not choose to use the hearing request form provided by APD, please make sure your hearing request includes the following information:

1. The name, social security number, address, and telephone number of the party making the request and the name, address and telephone number of the party's counsel or representative upon whom service of pleadings and papers must be made;
2. A statement that you are requesting an administrative hearing;
3. A list of any facts and circumstances on which you rely to assert an error in your cost plan adjustment;
4. A reference to, or copy of your Notice of Rebased Cost Plan;
5. A statement indicating the date you received your revised cost plan, and
6. If someone is making the request for hearing on your behalf, a document, such as an Order Appointing Guardian or a written statement of authorization, establishing the representative's authority to act on your behalf.

To request a hearing you must mail or deliver your completed request to the local APD area office.

COST PLAN REBASING (ADJUSTMENT)

HEARING REQUEST FORM

If you are adversely affected by the adjustment of your cost plan required by Section 395.0661(6), Florida Statutes, you may request a fair hearing. You may use this form for the request. Please remember to provide facts that show how APD made a mistake in calculating the adjustment to your cost plan. **File the completed form with your Area Agency for Persons with Disabilities office:**

Consumer's/Petitioner's Name: Address City/State/Zip: Phone Number: Social Security Number:	Representative's Name: Address: City/State/Zip: Phone Number:

[IF USING A REPRESENTATIVE, PLEASE PROVIDE WRITTEN AUTHORIZATION, GUARDIANSHIP ORDER, OR OTHER DOCUMENTATION FOR THIS PERSON TO REPRESENT YOU.]

I am requesting a hearing on APD's rebasing adjustment of my cost plan pursuant to Section 393.0661(6), F.S. I received notice of my cost plan rebasing on _____, 2010 (please enter date of receipt).

APD erred in reducing my cost plan because

_____

_____

_____

_____

[PLEASE ADD ADDITIONAL PAGES IF NECESSARY]

Signed,

_____ _____

[CONSUMER OR REPRESENTATIVE] **[DATE]**