



MFP Letter of Denial, Suspension or Termination

To: _____ Date: _____

Your participation in Money Follows the Person (MFP) has been given careful consideration. In accordance with Deficit Reduction Act of 2006, Money Follows the Person Demonstration P.L. 109-171, Title VI, Subtitle A, Chapter. 6, Subchapter B, Sec 6071, 120; as amended by the Affordable Care Act of 2010, P.L. 111-148, Title II, Subtitle E, Sec 2403(a), (b)(1), 124 Stat. 304, this letter is to inform you of a change in your participation.

A. **Denied** – According to the Georgia Money Follows the Person Policy and Procedures Manual Chapter 601.2, 601.4, 601.7 and 602.2, you have been determined **ineligible and are being denied participation in MFP** because:

- You have not resided in an inpatient facility (hospital, nursing facility, ICF/IDD, PRTF) for at least 90 consecutive days; short-term rehabilitative stays do not count. (D1)
- You have not been receiving Medicaid benefits for inpatient services provided by an inpatient facility. (D2)
- You do not require institutional level of care provided by an inpatient facility. (D3)
- You did not transition into a qualified residence. (D4)
- You did not cooperate in the transition planning process (describe process/steps and non-participation): _____ (D5)

B. **Suspended** – According to the Georgia Money Follows the Person Policy and Procedures Manual Chapter 604.6, you have been **temporarily suspended from participation in MFP** because:

- You have been readmitted to an inpatient facility for a period of thirty-one (31) days or more, but less than 6 months.

C. **Terminated** – According to the Georgia Money Follows the Person Policy and Procedures Manual Chapter 601.2, 601.4, 601.7, 602.2, 604.6, and Chapter 605.6 and 605.7, you have been determined **no longer eligible and are being terminated** because:

- You have been readmitted to an inpatient facility for a period of 6 months or more. (T1)
- You are no longer receiving Medicaid benefits. (T2)
- You have moved to a non-qualified residence. (T3)
- You no longer meet institutional level of care criteria. (T4)
- You have informed us that you no longer wish to participate in MFP. (T5)
- You have moved outside of the service area for the State of Georgia. (T6)
- You are a MFP CBAY participant and have been readmitted to an inpatient facility for 31 days or more. (T7)

MFP Field Personnel Signature

MFP Field Personnel (Print Name)

Telephone Number

If you disagree with this decision, you may request a fair hearing. Your request should be sent to the following address:



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NOTICE OF YOUR RIGHT TO A HEARING

To request a hearing, you must ask for one in writing. Your request for a hearing must be *received* by the Department of Community Health within 30 calendar days from the date of this letter. You must include a copy of this *MFP Letter of Denial, Suspension or Termination*. Your request should be sent to the following address:

Department of Community Health
Legal Services Section
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303-3159

If this action is sustained by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.

The Office of State Administrative Hearings will notify you of the time, place, and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member speak for you. You may also ask a lawyer for help. You may be able to get legal help at no cost. If you want a lawyer to help, you may call one of these numbers:

Georgia Legal Services Program

800-498-9469 (statewide legal services, except for the counties served by Legal Aid)

Georgia Advocacy Office

800-537-2329 (statewide advocacy for persons with disabilities or mental illness)

Atlanta Legal Aid

404-377-0701 (DeKalb/Gwinnett Counties)

770-528-2565 (Cobb County)

404-524-5811 (Fulton County)

404-669-0233 (S. Fulton/Clayton County)

State Ombudsman Office

866-552-4464