

Enter letter date

Enter First Name Enter Last Name State/Medicaid ID: Enter number

Enter Address

Enter City, Enter State Enter Zip Code

**Your Long-Term Care Application Status**

**Dear** Enter First Name Last Name,

**As of Enter Action Date (Letter Date + 11 days), you have been Enter Approval Status for Enter Program Name.**

This decision was made because Select Reason. The state rule that applies to this decision is 10 CCR 2505-10 Section Enter Rule Section.

You have the right to appeal this decision if you disagree with it. Instructions for how to appeal are on the next page.

If you have questions, please call Enter Case Management Agency Name at Enter Phone Number.

Sincerely,

Enter Case Management Agency Name

Case Manager Signature:

Supervisor Signature:

## If you disagree with our decision

If you disagree with this decision, you can ask for an informal review, file a formal appeal, or both. *Appeal* means you disagree with a decision and want a State Fair Hearing with a judge. You have the right to appeal any decision about your benefits, including whether you qualify and how much assistance you get.

**Asking for an informal review**

You can ask your case management agency for an informal review of the decision. If you also want to file a formal appeal, you must still do it by the deadline below, even if you also want to try an informal review. Call Enter Case Management Agency Name at Enter Phone Number.

**Filing a formal appeal**

If you want to appeal, **you must file your appeal by Enter Appeal Deadline (Action Date + 60 days).** You can file an appeal in any of these ways:

* Complete the form “Request for a State Fair Hearing” enclosed with this letter and attach a copy of this notice (keep a copy for your records). Mail, fax, or bring them to:

Office of Administrative Courts

1525 Sherman Street, 4th Floor

Denver, CO 80203

Fax: 303-866-5909

* You can also file an appeal online at [Colorado.gov/oac/oac-form-links](https://www.colorado.gov/oac/oac-form-links), or call the Office of Administrative Courts at 303-866-2000.

The Office of Administrative Courts will mail you the date, time, and place for your hearing. You have the right to represent yourself at your appeal hearing or you may choose a lawyer, relative, friend or any other person to be your representative. You may be able to get free legal help from Colorado Legal Services. Call 303-837-1313 or visit [coloradolegalservices.org](http://www.coloradolegalservices.org) for more information.

**Asking for an expedited (faster) hearing**

If you think waiting for a hearing might put your life or health at risk, you have the right to ask for an expedited (faster) hearing. If you want an expedited hearing, put it in the Request for a State Hearing form (enclosed) with your reasons for appealing.

**Receiving benefits while you appeal**

If you want to continue getting your benefits while you appeal (i.e. you ask for a formal hearing), you must file your appeal before your benefits end.

## If you think you have been treated unfairly

The Colorado Department of Health Care Policy & Financing does not discriminate on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, gender identity and expression, sexual orientation, marital status, religion, creed, political beliefs or disability in any of its programs, services, and activities.

To file a discrimination complaint or request free disability or language aids and services, contact the Colorado Department of Health Care Policy & Financing, 504/ADA Coordinator:

* US Mail: 303 E. 17th Avenue, Suite 1100, Denver, CO 80203
* Phone: 303-866-6010 or state relay 711
* Fax: 303-866-2828
* Email: [hcpf504ada@state.co.us](mailto:hcpf504ada@state.co.us)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights:

* Complaint Portal: [ocrportal.hhs.gov/ocr/cp/complaint\_frontpage.jsf](https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf)
* Complaint Forms: [hhs.gov/civil-rights/filing-a-complaint/index.html](https://www.hhs.gov/civil-rights/filing-a-complaint/index.html)
* US Mail: 1961 Stout Street, Room 08-148, Denver, CO 80294
* Phone: 800-368-1019, TDD: 800-537-7697
* Fax: 202-619-3818

**Request for a State Fair Hearing**

Complete this form if you disagree with the decision about your benefits and want to file a formal appeal. The Office of Administrative Courts must receive it by **Enter Appeal Deadline (Action Date + 60 days)**.

I disagree with the case management agency’s decision in the attached notice. I wish to appeal this decision and have my case considered by an Administrative Law Judge.

Your name: **Enter First Name** **Enter Last Name**

Your State/Medicaid ID: **Enter number**

Case Management Agency: **Enter Case Management Agency Name**

Your signature:

Today’s date:

Your address:

Your phone number:

I am appealing because:

I am requesting an expedited (faster) hearing because:

Help in Your Language

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| **Health First Colorado Member Contact Center:** 800-221-3943 (State Relay: 711) | |
| **Español** | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-221-3943 (State Relay: 711). |
| **Tiếng Việt** | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-221-3943 (State Relay: 711). |
| **繁體中文** | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-221-3943 (State Relay: 711). |
| **한국어** | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-221-3943 (State Relay: 711) 번으로 전화해 주십시오. |
| **Русский** | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-221-3943 (телетайп: 711). |
| አማርኛ | ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-221-3943 (መስማት ለተሳናቸው: 711). |
| **ةيبرعلا** | ﻣﻠﺤﻮظﺔ: إذا ﻛﻨﺖ ﺗﺘﺤﺪث اذﻛﺮ اﻟﻠﻐﺔ، ﻓﺈن ﺧﺪﻣﺎت اﻟﻤﺴﺎﻋﺪة اﻟﻠﻐﻮﯾﺔ ﺗﺘﻮاﻓﺮ ﻟﻚ ﺑﺎﻟﻤﺠﺎن. اﺗﺼﻞ ﺑﺮﻗﻢ  .(117 :واﻟﺒﻜﻢ اﻟﺼﻢ ھﺎﺗﻒ رﻗﻢ)3493-122-008-1 |
| **Deutsch** | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-221-3943 (State Relay: 711). |
| **Français** | ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-221-3943 (ATS: 711). |
| **नेपाल�** | ध्यान िदनहु ोस:् तपाइ�ले नेपाली बोल्नहु �न्छ भने तपाइ�को िनिम्त भाषा सहायता सेवाह� िनःशल्ु क �पमा उपलब्ध छ । फोन गनर्होस् 1- 800-221-3943 (िटिटवाइ: 711). |
| **Tagalog** | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-221-3943 (State Relay: 711). |
| **日本語** | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1- 800-221-3943（State Relay: 711）まで、お電話にてご連絡ください。 |
| **Oroomiffa** | XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-221-3943 (State Relay: 711). |
| **یسراف** | **ﺗﻮﺟﮫ**: اﮔﺮ ﺑﮫ زﺑﺎن ﻓﺎرﺳﯽ ﮔﻔﺘﮕﻮ ﻣﯽ ﮐﻨﯿﺪ، ﺗﺴﮭﯿﻼت زﺑﺎﻧﯽ ﺑﺼﻮرت راﯾﮕﺎن ﺑﺮای ﺷﻤﺎ ﻓﺮاھﻢ ﻣﯽ ﺑﺎﺷﺪ. ﺑﺎ  .ﺑﮕﯿﺮﯾﺪ ﺗﻤﺎس 1-800-221-3943 (State Relay: 711) |
| **Polski** | UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-221-3943 (State Relay: 711). |