

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

HUNTINGTON DIVISION

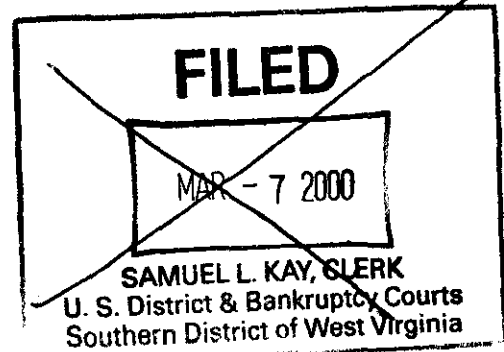
BENJAMIN H., by his next friend, Georgann H.,
DAVID F., by his guardian, Carolyn B.,
LORI BETH S., by her next friend, Janie J.,
THOMAS V., by his next friend, Patricia V., and
JUSTIN E., by his next friend, Sherry E.,
individually and on behalf of all others
similarly situated,

Plaintiffs,

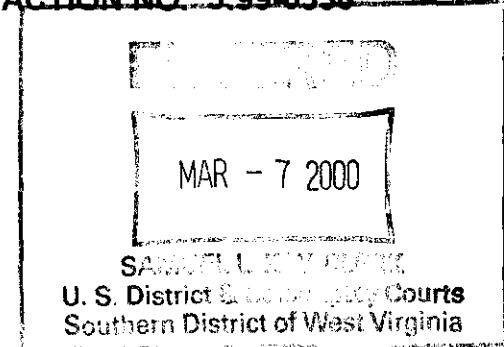
v.

JOAN OHL, Secretary of the Department
of Health and Human Resources,

Defendant.



CIVIL ACTION NO. 3:99-0338



ORDER

This day came the plaintiffs by counsel and the defendant by counsel and agreed that all prospective issues raised by Count IV (Opportunity to Apply) and Count VI (Medicaid and Due Process Notice and Hearing Rights) are compromised and settled on the terms hereinafter set forth, and thereupon

It is hereby ORDERED and DECREED that:

1. All persons who apply for Title XIX Home and Community Based Waiver Services are entitled to an eligibility determination within 90 days of the date of application, subject to the provisions of 42 C.F.R. § 435.911(a)-(e). At the time of such application, the applicant will receive a statement of his/her rights, including but not limited to, the right to an eligibility determination within 90 days and all rights contained in the attached "Notice

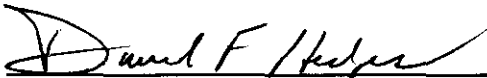
of Decision". Applications may be presented to a behavioral health center, the Waiver Program Coordinator, or any local DHHR office. No person shall be discouraged from applying.

2. All persons shall be afforded 90 days to request a hearing. Any applicant, recipient or authorized representative may request a hearing and must do so either by any written request or by using the attached "Request for Hearing". Those who request a hearing shall be entitled to a final administrative action within 90 days of the date of the request for a hearing pursuant to 42 C.F.R. § 431.244(f) unless the applicant waives the right to a final administrative action within 90 days.

3. DHHR shall use the attached "Notice of Decision" and "Request for Hearing" forms in all notices to applicants or recipients in Title XIX Home and Community Based Waiver contexts whenever services are denied, reduced, terminated, or delayed.

ENTER this the 6th day of March, 2000.


UNITED STATES DISTRICT JUDGE

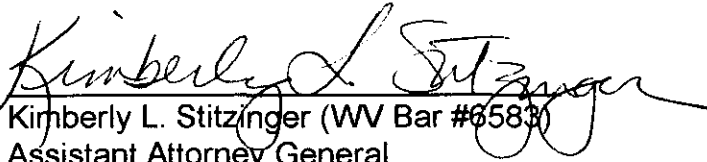

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COUNSEL FOR DEFENDANT

VERSION 06-95

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES (MEDICAID)
REQUEST FOR HEARING**

NAME: _____

ADDRESS: _____

RECIPIENT NAME and ID #: _____

TELEPHONE NUMBER WHERE YOU CAN BE REACHED: _____

I am requesting a fair hearing for the following reason(s):

Please list service that was denied or terminated. Be as specific as possible. Use other side of this form, if necessary for more space.

You may be contacted by a representative of the Department of Health and Human Resources regarding this request.

You may be requested to participate in a pre-hearing conference (most likely by telephone).

Which type of hearing would you prefer (please check one):

- _____ All persons participate by telephone conference.
- _____ In person at local office (Medical Consultant by telephone).
- _____ Hearing at Bureau for Medical Services office in Charleston. (with reimbursement for travel mileage, if requested.)

Signature: _____ Date: _____

If hearing is by telephone and you have any documents to present, please mail your documents before the hearing to the hearing examiner whose name is on the hearing notice that you will receive.

If you know you will be represented by an attorney or other individual, please list his/her name, address, and telephone number:

Check here if you know you will have a second medical exam in preparation for the hearing.

Return this request to: Bureau for Medical Services
Board of Review
Building 6, Capitol Complex
Charleston, West Virginia 25305

A Staff member will try to contact you by telephone within approximately five days of receipt of this form.

After the telephone contact, you will be notified in writing of the date and time of the hearing.

If we are unsuccessful in contacting you by telephone, you will receive written notice of the hearing date and time within 30 days.

Bureau of Medical Services
Policy Units
Room 251
350 Capitol Street
Charleston, West Virginia 25301-3707

NOTICE OF DECISION
STATE OF WEST VIRGINIA
DEPT. OF HEALTH & HUMAN RESOURCES

Worker Name:
Telephone: 1-800-642-8589
Telephone: 1-304-558-2400
Date:
Case Name:

Case Number:

Name: _____
Address: _____

Medicaid MR/DD Waiver Program

- Your Waiver Application is hereby denied.
- Your Waiver services have been terminated.

Your application was denied/terminated because:

The Reviewer(s) relied on the following facts: _____

You have right to a **second medical exam** at the department's expense if the decision was based on medical reasons. You have the right of **access to your file** and copies free of charge.

FAIR HEARING: If you do not agree with this decision, you may ask for a **Fair Hearing** and/or a Pre-Hearing Conference within 90 days of the action taken. A form to ask for a Fair Hearing and/or Pre-Hearing Conference is enclosed. If this action is termination of your benefit, your services may continue until your hearing is held. Within 90 days, you must complete this form and submit it to the address on the bottom of the form. You must ask for a Hearing/Pre-Hearing Conference within 13 days of the date of this notice in order to receive continued benefits. The following organizations provide **free legal services** to eligible persons: WV Advocates, 1207 Quarrier Street, Charleston, WV 25301, 1-800-950-5250; WV Legal Services Plan, Inc., So. 4th St., Doctor Bldg., Clarksburg, WV 26301, 1-304-623-6649; Appalachian Legal Services, 922 Quarrier St., 4th Floor, Charleston, WV 25301, 1-800-834-0598. The department will assist in arranging **transportation** if needed.

The **policy** upon which the decision is based: _____

cc: Behavioral Health Center provider