agency for persons with disabilities
State of Florida

NOTICE OF IMPLEMENTATION OF THE iBUDGET FLORIDA WAIVER
NOTICE OF A REDUCTION TO CURRENT ANNUAL COST PLAN

[Insert Date]
[Insert Name (C/O Legal Guardian, if applicable)]
[Insert Street Address]
[City, State, Zip]

iBudget Florida is a new flexible waiver that is replacing the four-tiered Home and Community-Based Services waiver (the HCBS waiver). Section 393.0662, Florida Statute, requires the Agency for Persons with Disabilities (APD) to implement iBudget Florida throughout the state. iBudget is designed to give you more choice and self-direction in selecting the services you want most and creating a cost plan that reflects your priorities. To review an online version of the iBudget Welcome Guide, go to iBudgetFlorida.org and click on “Basics,” then click iBudget Florida Welcome Guide.

Date of Transition to iBudget Florida

You will begin receiving services through iBudget Florida on July 1, 2012.

Your New Annual iBudget Amount

Your iBudget Florida annual budget amount for July 1, 2012, through June 30, 2013, is [ ]. This represents an annual reduction of [ ].

If you have questions about your iBudget allocation, please consult with your waiver support coordinator (WSC) or your APD area office to discuss any concerns.

Your Pre-Approved Services

You have been pre-approved for the services you are currently receiving in your tier waiver. You may choose to use your budget amount for these waiver services, or you may discuss your options for alternative services with your waiver support coordinator.

Although the names of some of your services may look different than the services you are currently receiving in your tier, we assure you that you are pre-approved for the same services you are currently receiving.

iBudget Florida has made these changes to the service array to allow you more flexibility when creating your cost plan. If you have questions about this, please contact your waiver support coordinator or refer to the iBudget Welcome Guide that was recently mailed to you or is available online as stated above.

Insert Identifier

If You Wish to Request a Hearing

You may request a hearing within thirty (30) days after receipt of this notice. If you request a hearing within ten (10) days, your currently authorized services will continue uninterrupted until the hearing is held and a final order issued. Please review the attached Notice of Administrative Hearing Rights for more information about requesting a hearing. In accordance with the Code of Federal Regulations, if you request a hearing and APD prevails, you may be held responsible for the excess cost of any service that was maintained at its current level because of the pending hearing process.

Your iBudget allocation amount and hearing rights are separate from any pending hearing matters. If you have another hearing pending unrelated to this notice, your iBudget amount may be adjusted when the results of that process become final.

The Agency for Persons with Disabilities is committed to protecting your health and safety. Additional information about iBudget Florida can be found at iBudgetFlorida.org and APDcares.org. You may also contact your WSC or your APD area office.

Attachments: Notice of Hearing Rights
Hearing Request Form

NOTICE OF ADMINISTRATIVE HEARING RIGHTS

You have the right to an administrative hearing before the Office of Appeal Hearings, Department of Children and Family Services to dispute that decision. At that hearing, you will have an opportunity to present evidence on all issues, to conduct cross-examination and submit rebuttal evidence, to submit proposed findings of facts and orders, to file exceptions to the presiding officer's recommended order, and to be represented by counsel or a qualified representative. The Agency for Persons with Disabilities will request that the hearing be conducted locally, for your convenience. Section 393.125(c), Florida Statutes, states that your hearing request must be received by the Agency, in writing, within 30 days of your receipt of this notice. If APD has notified you that it intends to reduce, terminate or suspend Medicaid Waiver services you are already receiving, your hearing request must be received within 10 days of your receipt of this notice to continue to receive those services pending a decision after the hearing. Additionally, section 120.54(5)(b)5., Florida Statutes, requires that you include the following information in your hearing request:

1. The name, 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 and dispute the facts alleged by the Agency, in which case the facts in dispute must be identified, or that you are requesting a hearing but do not dispute the facts underlying the Agency's decision;
3. A reference to, or copy of, this Agency decision and the date you received it.

Please be advised that mediation is not available in this proceeding.

To request a hearing, send your hearing request to your Local Area APD Office:

[AREA CONTACT PERSON]
[AREA ADDRESS]

If you make your request for a hearing within ten (10) days of receipt of this notice, your current authorized services will continue uninterrupted until the hearing is held and a final order issued.

In accordance with Code of Federal Regulations, 42 CFR 431.230, if you request a hearing and the Agency prevails, you may be held responsible for the excessive cost of any service that was maintained at its current level because of the pendency of the hearing process.

You may contact your Local Area APD Office for more information or if you need assistance in filing your hearing request.

HEARING REQUEST FORM

If you are adversely affected by this decision, you may request a hearing. You may use this form for the request.

You must file your hearing request with your APD area office either by mail, hand delivery or facsimile.

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

I am requesting a hearing on APD's decision regarding my services. I received my notice on _____ , 20___ [**DATE**].

I do dispute the facts or reasons stated in my notice. APD erred in changing my service request(s) or authorization(s) because: [**LIST REASONS OR DISPUTED FACTS.**]

_____
_____
_____
_____
_____ **[PLEASE ADD ADDITIONAL PAGES IF NECESSARY.]**

Signed,

_____ _____

[CUSTOMER OR REPRESENTATIVE] **[DATE]**

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