Functional Assessment Instrument
Level of Care Score Outcome

_____ _____

Customer Name (First and Last) Beneficiary Identification Number

Upon completion of the Functional Assessment Instrument (FAI), the customer's level of care score has:

_____ **Met** the Medicaid Waiver Threshold Criteria.

_____ **Not Met** the Medicaid Waiver Threshold Criteria.

READ THE CUSTOMER RIGHTS AND RESPONSIBILITIES.

Right to Appeal: You have the right to a fair hearing if you are dissatisfied with the decision made on your level of care score or feel there has been undue delay in acting on your application. You have the right to request a fair hearing if you disagree with the outcome of this functional assessment instrument.

If you want a fair hearing, you must submit a written request within 63 days of this notice. At the hearing, you will be given the opportunity to explain why you disagree with this notice. You may represent yourself or a household member, legal counsel, friend, relative, or other spokesperson may represent you. Failure to request a fair hearing within 63 days of this notice could adversely affect your rights.

A Written Request for a Fair Hearing should be sent to:

Office of Administrative Hearings, 1020 S. Kansas Ave., Topeka, Kansas, 66612

Rights and Responsibilities: As a customer, you must cooperate in the annual review of your level of care and services, and any necessary evaluations and/or audits conducted by the Kansas Department for Aging and Disability Services. You have the same rights to available services provided to persons in your category of Medicaid eligibility. You have the right to equal treatment as other applicants/recipients who are in similar situations.

My signature below indicates that I have been informed of my level of care score outcome based on my completed Functional Assessment Instrument and that I have been read my customer my rights and responsibilities.

_____ _____

Customer or Authorized Representative Signature Date

_____ _____

Functional Assessor Date

Civil Rights: No person shall, on the grounds of race, color, national origin, age, disability, religion, or sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity of the Kansas Department for Aging and Disability Services and/or the Department of Children and Families. If you feel that you have been discriminated against on the above grounds, you may make a complaint in writing to the Department of Administration or the United States Department of Health and Human Services.