## **Functional Assessment Instrument Level of Care Score Outcome**

Customer Name (First and Last)	Beneficiary Identification Number
Upon completion of the Functional Assessment Instru	ment (FAI), the customer's level of care score has:
Met the Medicaid Waiver Threshold Criteria Not Met the Medicaid Waiver Threshold Criteria.	
Right to Appeal: You have the right to a fair hearing level of care score or feel there has been undue delay is request a fair hearing if you disagree with the outcome	
will be given the opportunity to explain why you disag	request within 63 days of this notice. At the hearing, you gree with this notice. You may represent yourself or a other spokesperson may represent you. Failure to request rsely affect your rights.
A Written Request for a Fair Hearing should be se	nt to:
Office of Administrative Hearings, 1020 S. Kansas Ave., Topeka, Kansas, 66612	
Rights and Responsibilities: As a customer, you must services, and any necessary evaluations and/or audits of Disability Services. You have the same rights to availate Medicaid eligibility. You have the right to equal treatrisituations.	able services provided to persons in your category of
My signature below indicates that I have been informed completed Functional Assessment Instrument and that responsibilities.	
Customer or Authorized Representative Signature	Date
Functional Assessor	Date

<u>Civil Rights:</u> 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.