471-000-103 Instructions for Completing Form HSS-6, "Client Notice of Action"

Use: Form HSS-6 is used by the worker each time a determination of eligibility is made and whenever a service is changed, reduced, terminated, or denied.

Completion: Form HSS-6 is completed by the worker and mailed to the applicant/client or his/her legal representative.

"To": The worker enters the name of the client (or his/her legal representative) and Social Security number of the client. Note: If Form HSS-6 is addressed to the legal representative, the client's name must also be included on the form.

For example - To: John Smith (legal representative)
For Jane Brown (client/applicant)
509-99-9999 (client Social Security number)

Paragraph 1: The worker checks the box and completes this section when the applicant/client has been determined eligible for services.

The worker enters the service or services for which the client is eligible.

The worker enters the date eligibility begins (this matches dates on the application and other forms) and the date eligibility ends (the eligibility period cannot be longer than one year from the eligibility beginning date).

Paragraph 2: The worker checks the box and completes this section when services for the client have been changed, denied, reduced, or terminated. The worker mails the completed Form HSS-6 to the client at least 10 days before the effective date if a service is being reduced or terminated.

The worker enters the name of the service.

The worker enters the appropriate action (listed below the line) being taken on the case and the date of the last day the client will receive services if the service is being reduced or terminated.

The worker enters the reason for the action citing the appropriate manual reference.

Paragraph 3: The worker checks the box and completes this section when the applicant/client has been determined ineligible.

The worker enters the reason for the decision citing the manual reference.

Further information regarding your services: The worker uses this space to provide any information the client needs regarding the action taken or attaches a separate page and indicates attachment in this space.

Signature: The worker signs Form HSS-6 and enters his/her office address and telephone number.

Reverse Side: Boxed space is provided for client or legal representative mailing address when window envelopes are used.

A listing of client rights is provided and should be used by workers to assist clients in exercising their rights.

Distribution: Form HSS-6 is a one-page NCR form with two copes distributed as follows:

1. White copy is mailed to the applicant/client or his/her legal representative; and
2. Yellow copy is retained by the local office.

Retention: The yellow copy of Form HSS-6 is retained in the local office client file for four years.

NOTICE OF ACTION
Nebraska Department of Health and Human Services

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

TO: _____ _____
Name Social Security Number

☐ Your application for services has been reviewed. **The information available to us at this time indicates that you are eligible for services according to state law.** The service(s) you will receive, _____ (List Service), _____ (List Service), is based on your request and state regulations. You are eligible from _____ through _____, unless your circumstances change.

☐ This is to notify you that _____ (List Service) service(s) will be _____ (Changed, Denied, Reduced, Discontinued) after _____ (Date)
The reason for this decision is _____

However, if you file an appeal (see reverse) within ten days following the date of this notice, the service(s) you are now receiving will continue until a hearing is held and a decision is made on the appeal.

☐ Your application for services has been reviewed. **The information available to us at this time indicates that you are not eligible for services according to state law.** The reason for this decision is _____

Further information regarding your services:

If you have questions, please contact me.

_____ _____
Signature Date

_____ _____
Address Telephone Number

_____
Service Office
_____
Address
_____
City, State, Zip

FOR LOCAL OFFICE STAMP

printed on recycled paper

Please read the back of this notice for your rights.
Distribution: WHITE - Client; YELLOW - Local Office

HHS-6 Rev. 4/01 (27010)
(Previous version DSS-6 9/98 should be used first)

YOUR RIGHTS

CIVIL RIGHTS

No person may be subjected to discrimination in any Department of Health and Human Services program or activity based on his/her race, color, sex, age, national origin, religious creed, political beliefs or handicap. Any person who believes s/he has been subjected to discrimination may file a complaint with the Nebraska Department of Health and Human Services or with the U.S. Department of Health and Human Services.

RIGHT TO A CONFERENCE

You have the right to request a conference with your worker to discuss the reason(s) for the action(s) indicated on this form. To request a conference, you can call, write, or visit the local office. If you have questions about your application, payment or medical assistance, your worker will be glad to discuss your case with you.

RIGHT TO NOTICE OF ACTION

Adequate notice must be sent notifying you of any action(s) affecting your assistance case. Adequate means the notice must include a statement of what action(s) the local office intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s).

In cases of intended adverse action (action to discontinue, terminate, suspend or reduce your assistance, or to change the manner or form of your payment or service to a more restrictive method) you must receive adequate and timely notice. Timely mans that the notice is mailed at least ten calendar days before the date the action would become effective, which is always the first day of the month. In certain situations, your worker may dispense with timely notice but shall send you adequate notice no later than the effective day of action. Your worker can explain these situations to you.

In cases where the local office obtains facts indicating that your assistance should be discontinued, suspended, terminated, or reduced because of probable fraud, and where possible, such facts have been verified through collateral sources, notice of such grant adjustment is considered timely if it is mailed at least five days before the action would become effective.

RIGHT TO APPEAL

You have the right to appeal for a hearing or inaction of any state employee or official with regard to application for or receipt of financial or medical assistance. You may appeal because your application for financial or medical assistance is denied or is not acted upon with a reasonable promptness; your assistance is suspended, reduced, discontinued or terminated; your form of payment or services is changed to a more restrictive method or because you feel the action taken by the local office with erroneous. A hearing need not be granted when either state or feral law requries automatic case adjustemens for classes of clients unless the reason for an individual appeal is incorrect eligibility determination.

If you request assistance from the local office under the Emergency Assistance Program, and the local office did not help you with your request, you may apeal the local office's actions or inactins to the Nebraska Department of Health and Human Services and that office will provide you with a quick hearing and decision on your appeal. You may ask your worker for more information regarding the expedited appeal. 468 NAC 6-012.01.

You (or your representative) have 90 days following the date the notice of finding is mailed to request a fair hearing.

In cases of intended adverse action where the worker is required to send you timely and adequate notice, if you request an appeal hearing within ten days following the date the notice of finding is mailed, your worker shall not carry out the adverse action until a fair hearing decision is rendered. This regulation does not apply to those situations where the worker may dispense with timely notice and is only required to send you adequate notice.

This regulation in no way restricts your worker from continuing normal case activities and implementing changes to your assistance case that are not directly related to the appeal issue.

If, as a result of the hearing, the action taken by the local office is found to be correct, the disputed amount of assistance provided to you during the appeal period may be treated as an overpayment and recovery procedures may be initiated by the local office.

To file an appeal, you may contact the local division of social sarices or the Nebraska Department of Health and Human Services. Your worker will explain the appeal procedure and assist you in completing the appeal form. The appeal request must be in writing.

Once you've filed the appeal, arrangements for a hearing will be made and you will be notified of the time and place. You may represent yourself at the hearing or be represented by another person.