



**NOTICE OF ELIGIBILITY APPEAL DECISION HEALTHY WAY LA
Uphold Decision**

Date:

Name: ***(Insert Applicant Name or Representative)***

Applicant's Name:

Address:

City, State, Zip

DMH IS #: ***[insert number]***

Dear ***(Insert Applicant Name or Representative):***

A decision has been made about your appeal to deny your membership in the HWLA Program. The decision was made on [insert decision date].

After careful review, our reviewer agrees with the original decision because ***(insert a clear and concise explanation of the reason for the decision. The detail may contain a description of the eligibility criteria, or other resource used, including a citation of the specific rule supporting the action).***

This means that you are not eligible for the HWLA Program.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TTD at (800) 735-2929.

If you do not agree with this decision, you have the following appeal rights:

1. You can ask for a State Fair Hearing. You must ask for a State Fair Hearing within **90 days** from the date on this letter.

To request a State Fair Hearing, call 1(800) 952-5253. If you have trouble hearing or speaking, you can call TTY/TDD at 1(800) 952-8349. You may also ask for a State Fair Hearing by writing to:

**California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430**

Please send us a copy of your request for a State Fair Hearing if you file one.

The County of Los Angeles has other programs you may be eligible for to help pay for the cost of medical care. You may want to go back to the facility where you applied for HWLA and find out if any of these programs can help you.

Please call DMH Patients' Rights at (213) 738-4949 or TTY/TDD at (800) 735-2929 if you have any questions.

Sincerely,

(Name of RMD Representative)

c: DMH Patients' Rights