



Home Care Program Notice of Action/Waiver

To: _____ From (ASAP): _____

Date: _____

Dear _____:

We are writing to notify you of a change in your Home Care Program services based on your current circumstances.

Your services will be:

☐ **reduced** from _____
to _____ on _____ (date).

☐ **terminated** on _____ (date). You will no longer receive
waiver program home care services.

Reason: _____

The above decision is based on Section _____ of the Home Care Program
regulations of the Executive Office of Elder Affairs, which states: _____

You have the right to appeal this decision. If you wish to appeal this decision, you must send the enclosed Request for Review to the Aging Services Access Point at the address above within 30 calendar days of when you get this Notice of Action. During the appeal process, your services will be continued at their present level.

Please call me at _____ if your situation changes or if you have any questions.

Sincerely,

Case Manager

Attachments: Your ASAP Appeal Rights
Request for ASAP Review