



Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Executive Office of Elder Affairs

## Home Care Program Notice of Action

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 Home Care Program 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 14 calendar days of when you get this Notice of Action.

If you choose to appeal, during the appeal process your services:

- will be continued at their present level.  
 will be continued at the reduced amount noted above.  
 will not be continued.

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