ACTION NOTICE and REVIEW RIGHTS – for Non-Medicaid Beneficiaries

CMHSJC

Consumer Name: Billable, Bob **Consumer ID #:** 9714

To: Guardian/Parent (as appropriate) Billable, Reta **Date:** 08/05/2016

This is to notify you that CMHSJC has made the following decision(s) about the service(s) you have asked for or the service(s) you get from us. This does not affect other services you are getting, or may need in the future.

The Action we have taken is:

[X] **The service(s) you requested** [X] **were** [ ] **will be**

(√ one only) **Name of Service(s) Affected:** **Effective Date:** 08/05/2016

- [X] Denied — Therapy and Med Clinic Services
- [ ] Delayed more than 14 days
- [ ] Authorized per completion and approval of your Individual Plan of Service
- [ ] Authorized per your Individual Plan of Service revision

  Describe Changes: _____
- [ ] Other Define: _____

[ ] **Your current service(s) will be:**

(√ one only) **Name of Service(s) Affected:** **Effective Date:**

- [ ] Reduced
- [ ] Terminated
- [ ] Suspended

The Reason for the Action is:

[X] **Eligibility**

- [X] You do not meet the clinical eligibility criteria for services. You do not meet eligibility criteria for services as a person with a serious mental illness, a person with a developmentally disability, a child with a serious emotional disorder or a person with a substance abuse disorder.
  - [X] You have other resources available for services. Please contact:
    - [X] your insurance company
    - [ ] your primary care doctor
    - [ ] a community provider agency
- [ ] Residency. You live outside of St. Joseph County. We cannot authorize services for you.
- [ ] You are currently residing in an institution in which Community Mental Health of St. Joseph County can not authorize your services. (e.g. jail, prison, state hospital, extended care facility)

[ ] **Medical Necessity** The service(s) requested or the current service(s) identified in this notice are not medically necessary for the following reason(s):

- [ ] The documentation provided does not establish medical necessity.
- [ ] Your Individual Plan of Service goals and objectives have been met.
- [ ] You have not attended or participated in your authorized services since _____

  CMHSJC cannot continue to authorize services for you if you are not interested.

[ ] **Other**

- [ ] The services are not covered services Community Mental Health of St. Joseph County provides.

  Please Contact: _____
- [ ] You have requested the termination of services.

The legal basis for this decision is M.C.L. 330 1001 et seq.

IF YOU DO NOT AGREE WITH THIS ACTION, PLEASE READ YOUR RIGHTS ON THE FOLLOWING PAGE.

Notice has been provided: [ ] via mail [X] in person on 08/05/2016

Consumer/Guardian Signature (as available)	Date	Staff Signature	Date
		Michelle Heffner, LMSW, CAADC	08/05/2016

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If you do not understand any part of this Notice, please call CMHSJC Customer Services at (269) 467-1000 or 1-800-622-3967 or TDD 269-382-0847

Your Rights:

If you were denied access to all services or psychiatric hospitalization by CMHSJC, you can request a Second Opinion.

- If a denial of all services, a Second Opinion will be completed within 5 business days of your request.
- If a denial for hospitalization, a Second Opinion will be completed within 3 business days.
- To request a Second Opinion, please contact CMHSJC Customer Services at (269) 467-1000 or 1-800-622-3967 or TDD 269-382-0847.

If you are not happy with the action we have taken, you may do any or all of the following:

- Ask to review your services/plan with your primary clinician or their supervisor (Informal Conflict Resolution); and/or
- Contact the CMHSJC Recipient Rights Office by calling (269) 467-1000; and/or
- Request a Local Appeal within 45 days by calling our CMHSJC Customer Services; and/or

You may choose to have another person represent you in exercising your rights – as your authorized representative. This person may be your legal counsel (attorney), a relative, a friend, service provider, your legal guardian (with copy of guardianship papers provided) or another spokesperson. You must give this person written permission to represent you, but you may not need to grant written permission if this person is your spouse or attorney.

Local Appeal Resolution

If you do not agree with this decision, you or your provider (on your behalf and with your written permission) may request a Local Level Appeal. Your request can be made orally or in writing and must be received by CMHSJC Customer Services within 45 calendar days of the Date of this Notice.

Community Mental Health of St. Joseph County

Access Supervisor
677 East Main St., Suite A,
Centreville, MI 49032

(269) 467-1000 or 1-800-622-3967 or TDD 269-382-0847

You have a right to request an "expedited" or "faster" appeal if waiting the standard time of 45 calendar days for the appeal would seriously jeopardize your life or health or your ability to attain, maintain or regain maximum function. To request an expedited hearing, you must call CMHSJC Customer Services.

Note: If you file an appeal you may ask that your services remain in place if you appeal within 12 calendar days of this notice, if the authorization has not expired, if the action is a reduction, termination, or suspension, and if the authorization was ordered by an authorized provider. If we are unable to honor your request to continue services, we will let you know. If services remain in place, you may be asked to repay the cost of these services if the appeal upholds the decision, or if you withdraw your appeal.

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Electronically Signed by:

Michelle Heffner, LMSW, CAADC 08/05/2016

Clinician's Signature & Credentials: Date

Others Signature

Participant's Signature	Name/Relationship/Title	Date	Comment
	Michelle Heffner, LMSW, CAADC	08/05/2016	