

To:

APPLICANT/~~CLIENT'S~~ MEMBER'S NAME ~~ADDRESS~~

APPLICANT/MEMBER'S ADDRESS

REPRESENTATIVE'S NAME ~~ADDRESS~~

REPRESENTATIVE'S ADDRESS

FROM:

NAME OF AGENCY

ADDRESS

CONTACT PERSON/NUMBER

OUR DECISION:

This decision concerns:

| | |
|---|---|
| <input type="checkbox"/> Your eligibility for SMI services | <input type="checkbox"/> Your outpatient or inpatient service plan |
| <input type="checkbox"/> Fees | <input type="checkbox"/> A change in your services |
| <input type="checkbox"/> Your clinical assessment | <input type="checkbox"/> Other |

OUR DECISION IS:

THE EFFECTIVE DATE OF THIS DECISION IS:

THE REASON FOR OUR DECISION IS:

DATE OF DECISION: _____ **(AN APPEAL MUST BE FILED WITHIN 60 DAYS OF THIS DATE)**

YOUR RIGHT TO APPEAL:

HOW TO APPEAL

Within 60 days of this decision, you may appeal orally by calling [local number] or [toll free number], or in writing by completing the AHCCCS Appeal or Serious Mental Illness Grievance Form, and sending it to [address]. Your appeal will begin at the RBHA. If your appeal is not resolved, you have a right to request an administrative hearing.

CONTINUED BENEFITS

If this decision concerns services you are currently receiving and if you appeal, your services will continue throughout the appeal process, unless a qualified clinician determines that the change is required to avoid a serious or immediate threat to your health or safety, or that of another person.

HOW TO GET HELP WITH YOUR APPEAL:

Any adult ~~client-member~~ or ~~client's-member's~~ legal guardian may represent himself, use a designated representative or legal counsel. To get help with this appeal you may contact the State Protection and Advocacy System, the Arizona Center for Disability Law, at 1-800-922-1447 in Tucson and 1-800-927-2260 in Phoenix. You may also contact the AHCCCS Office of Human Rights at (602) 364-4585 or 1-800-421-2124 in Phoenix, (928) 214-8231 or 1-877-744-2250 in Flagstaff, and (520) 770-3100 or 1-877-

524-6882 in Tucson. You may also refer to your member handbook for more information about the appeals process.

Name ~~and Signature~~ of Individual Completing this Form

Signature of Individual Completing this form

For translation or alternative format requests, call [insert 1-800 and local number] ~~Para recibir esta forma en español, llame a: [insert 1-800 and local number]~~¹

OPEN UNTIL 07/15/19

¹ Removed; AHCCCS does not provide policy translation