~~ACOM POLICY 446, ATTACHMENT A,~~
~~AHCCCS APPEAL OR SERIOUS MENTAL ILLNESS GRIEVANCE FORM~~

OPEN UNTIL 08/30/19

MEMBER/APPLICANT INFORMATION

NAME (LAST, FIRST, ~~M~~MIDDLE ~~.~~INITIAL~~.~~): ______________________ *DATE:* __________

ADDRESS: ______________________ *CITY:* __________ *STATE:* __________

ZIP CODE: __________ *PHONE:* __________ *DATE OF BIRTH:* __________

RELATIONSHIP TO THE MEMBER/APPLICANT:
(i.e. Provider, Parent, or Guardian) ______________________

NAME OF ~~PERSON~~ INDIVIDUAL[1] FILING FORM (IF DIFFERENT FROM ABOVE)

NAME (LAST, FIRST, MIDDLE INITIAL~~M.I.~~): ______________________ *DATE:* __________

ADDRESS: ______________________ *CITY:* __________ *STATE:* __________

ZIP CODE: ______________________ *PHONE:* __________

~~*ZIP CODE:*~~ __________ ~~*PHONE:*~~ __________

DESCRIPTION OF APPEAL OR GRIEVANCE: (Please include dates, names, locations, also any other attempts to resolve the problem, attaching additional pages as necessary.)

WHAT SOLUTION DO YOU WANT?

[1] Revised from ‘person’ to ‘individual’

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CONTINUATION OF SERVICES:
For members with a Serious Mental Illness, your services under appeal will be continued during the appeal process, unless doing so poses a serious threat of harm to you or others.

For appeals relating to Title XIX or XXI services, please check *one* of the following:

☐ I am requesting that the services I am appealing be continued during the appeal process. I understand that if I lose my appeal, I may be required to pay for the cost of the services that were continued during the appeal process.

☐ I do not want the services I am appealing to be continued during the appeal process.

CLIENT PERSON'S MEMBER/APPLICANT[2] SIGNATURE: ______________________ DATE: __________

PROVIDER, PARENT, OR GUARDIAN SIGNATURE: ______________________ DATE: __________

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[2] Revised to Member/Applicant to align with section above