ADEQUATE NOTICE (MEDICAID)

PLAN OF SERVICE

Note: Another form may be used as long as it includes all of this information and addresses each of the included areas.

Client Name: _____ Case Number: _____Date: _____

Client Medicaid ID: _____ County of Residence: _____

The Attached Plan of Service developed through the individual treatment planning process describes those services which have been authorized.

The Community Mental Health Services Program is responsible for the authorization of these services. The legal basis for any utilization review decisions made during the approval of this plan is 42 CFR 440-230 (d), 42CFR Chapter IV, Subpart F, Sections 438.402 to 424, MDCH-MSA Policy Bulletin: Medicaid Eligibility Manual – Beneficiary Hearings.

If you do not agree with the scope, duration or amount of the services and supports included in the Plan, you may use the **Local Appeal Process**. You may do **any one (or more)** of the following to discuss any problem you may have:

a. Contact your service provider / therapist: _____ at _____
b. Contact his/her supervisor: _____
c. Contact the CMHSP Recipient Rights representative to file a grievance or rights complaint:
Muskegon 231-724-1174; Ottawa 616-393-5763; West MI CMH (Lake, Mason, Oceana Counties) 1-800-992-2061

IF YOU ARE ENROLLED IN MEDICAID

If you are enrolled in Medicaid, you may **also** request an Administrative Hearing before an Administrative Law Judge. Hearing requests must be made by you (or the person you choose to represent you) in writing and received by the Department of Community Health within **90 days** of the date the person centered plan was signed.

To request an Administrative Hearing, complete a Request for Administrative Hearing (form, instructions and envelope attached) or write to the Administrative Tribunal at:

Administrative Tribunal
Department of Community Health
P.O. Box 30763
Lansing, MI48909-7695
1-877-833-0870

IF YOU ARE NOT ENROLLED IN MEDICAID

If you are **NOT enrolled in Medicaid** and/or **after you have completed the all Local Appeal Process levels described above,** you may request a Department of Community Health Alternative Dispute Resolution Review within 10 days, if your complaint has not been resolved, by contacting:

Michigan Department of Community Health
Division of Program Development, Consultation and Contracts
ATTN: Request for DCH Level Dispute Resolution – Substance Abuse
Lewis Cass Building – 6th Floor
Lansing, MI48913

☐ Notice has been mailed to: _____ date: _____

☐ Notice has been hand-delivered to: _____date: _____

-Client Signature of receipt: _____

LAKESHORE REGIONAL PARTNERS