Grievance and Appeals Procedure and Related Notices

NOTICE OF GRIEVANCE AND APPEALS RIGHTS

Client Name	
Case Number	
Date	
Client Medicaid ID Service Provider-Agency	
Location/County of Residence	

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

The CMHSP 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, and Sections 438.402 to 424, MDCH-MSA Policy Bulletin: Medicaid Eligibility Manual – Beneficiary Hearings.

THE ACTION WE HAVE TAKEN IS:

☐The service(s) requested☐ were ☐ will be

Table #1	**Name of Service(s) Affected**	**Effective Date**
☐ Denied		
☐ Delayed more than 14 days		
☐ Authorized per completion and approval of your initial or annual Individual Plan of Service		
☐ Authorized per your revised Individual Plan of Service	Describe Changes:	
☐ Other	Define:	

☐Your current service(s) will be:

A 12 calendar day advance notice from today's date is required (see instructions for exceptions).

Table #2	**Name of Service(s) Affected**	**Effective Date**
☐ Reduced		
☐ Terminated		
☐ Suspended		

THE REASON FOR THE ACTION IS (CHECK AS APPROPRIATE):

☐ **A. Eligibility**

- ☐ You do not meet the clinical eligibility criteria for services.
- ☐ Residency (You live outside of the LRP service area. We cannot authorize services for you.)

☐ **B. 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: (date)

☐ **C. Other:** _____

☐You have requested the termination of services.

☐ Notice has been mailed to:_____date: _____

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

-Client Signature of receipt: _____

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:

1. You (or the person chosen to represent you) may request a Local Appeal within 45 days of notice and you can do that by contacting your local service provider or by calling the local CMHS at the numbers provided below.
2. You (or the person chosen to represent you) have the right to file a Medicaid or Recipient Rights complaint. You may contact the local CMHSP Recipient Rights representative at the numbers provided below.
3. Contact your service provider / therapist: _____at:_____
4. Contact his/her supervisor:_____

Expedited Local Appeal Resolution:

You have a right to 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 the Customer Service Office at the number above.

Local CMHSP Contact Info: West MI CMH (Lake, Mason, Oceana Counties) at 1-800-992-2061; Muskegon at 231-720-3201, Ottawa at 616-494-5545.

IF YOU ARE ENROLLED IN MEDICAID

1. **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.
2. To request an Administrative Hearing, complete a Request for Administrative Hearing (form, instructions and envelope attached) or write to the Administrative Tribunal at:

Michigan Administrative Hearing System
Department of Licensing and Regulatory Affairs
611 W. Ottawa Building St. 4th Floor
P.O. Box 30475
Lansing, MI 48909

3. If you have requested an Administrative Hearing prior to the "Date of Action" or if we have not given you the required advance notice, benefits will continue pending the resolution of the Hearing. If your appeal is denied, you may be required to pay the costs of services received during the Appeals Process.
4. You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call toll-free,-1-877-833-0870.
5. Contact the local CMHSP if you believe you are entitled to Michigan State Medicaid Plan services other than those which have been changed.

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, MI 48913

Expedited Fair Hearing

You have a right to an "expedited" or "faster" hearing if waiting for the standard time (up to 90 days) for a hearing 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 the Administrative Tribunal office toll free at 1 877-833-0870.

STATE APPEAL:

If you are or are not enrolled in Medicaid and after you have completed the Local Appeal Processes described above, you may request in writing a Department of Community Health Alternative Dispute Resolution Review within 10 days of receiving the notice 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 MI 48913

REQUEST for HEARING
INSTRUCTIONS

You may use this form to request a hearing. You may also submit your hearing request in writing on any paper.
A hearing is an impartial review of a decision made by the Michigan Department of Community Health or one of its contract agencies that client believes is wrong.

GENERAL INSTRUCTIONS:

- Read ALL instructions FIRST before completing the form.
- Complete **Section 1**.
- Complete **Section 2** only if you want someone to represent you at the hearing.
- **Do NOT complete** Section 4.
- Please use a PEN and PRINT FIRMLY.
- Make a copy for your records.
- If you have any questions, please call toll free: **1 (877) 833 – 0870**
- After you complete this form, mail it in the enclosed self-addressed, postage paid envelope or mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763
LANSING MI 48909

- You may choose to have another person represent you at a hearing.
  - → This person can be anyone you choose by he/she must be at least 18 years of age.
  - → You MUST give this person written permission to represent you.
  - → You may give written permission by checking **YES** in **SECTION 2 and having the person who is representing you complete SECTION 3. You MUST still complete and sign SECTION 1.**
  - → Your guardian or conservator may represent you. A copy of the Court Order naming the guardian/conservator must be included with this request.

• The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. • If you need help with reading, writing, or hearing, you are invited to make your needs known to the Department of Community Health.	
If you do not understand this, call the Department of Community Health at (877) 833-0870. Si Ud. No entiendeesto,llame a la oficina del Departamento de Salud Comunitaria.	**1 (877) 833 - 0870**
Completion:	Is Voluntary

See the Request Form on Reverse

REQUEST FOR HEARING

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30763
LANSING, MI 48909
1 (877) 833-0870

SECTION 1 – To be completed by PERSON REQUESTING A HEARING:

Your Name			Your Telephone Number ( )	Your Social Security Number
Your Address (No. & Street, Apt. No.)			Your Signature	Date Signed
City	State	ZIP Code		
What **Agency** took the action or made the decision that you are appealing				Case Number
I WANT TO REQUEST A HEARING: The following are my reasons for requesting a hearing. ***Use Additional Sheets if Needed.***				
Do you have a physical or other condition requiring special arrangements for you to attend or participate in a hearing? ☐ **NO** ☐ **YES**(Please Explain in **Here**):				

SECTION 2 –Have you chosen someone to represent you at the hearing?

Has someone agreed to represent you at a hearing? ☐ **NO** ☐ **YES**(If YES, have the individual complete section 3)

SECTION 3 – Authorized Hearing Representative Information:

Name of Representative			Representative Telephone Number ( )	
Address (No. & Street, Apt. No.)			Representative Signature	Date Signed
City	State	Zip Code		

SECTION 4 – To be completed by the AGENCY distributing this form to the client

Name of Agency:			Lakeshore Regional Partners 376 E. Apple Ave. Muskegon, MI 49442
AGENCY Address (No. & Street, Apt. No.):			
City	State	ZIP Code	