ADHS/DBHS Policy Form 113.1
NOTIFICATION OF PERSON IN NEED OF SPECIAL ASSISTANCE

A T/RBHA, provider, or other person qualified to make the determination that determines a person ***with a Serious Mental Illness (SMI)*** *is in need of Special Assistance, in accordance with ADHS/DBHS Policy and Procedures Section 113, must notify the ADHS/DBHS Office of Human Rights within five (5) days of the determination. If the person is not already identified as Special Assistance, notification is required even if someone is involved and assisting the person.*

Part A: Notification (to be completed by the T/RBHA, provider or other person qualified and sent to the Office of Human Rights at (602) 364-4590 or via secure e-mail to OHRts@azdhs.gov)

The following person, **who is a person determined to have a Serious Mental Illness (SMI)**, is in need of Special Assistance.

First Name _____ Last Name _____ DOB _____ Residence Type _____

Address _____ City _____ State Arizona Zip code _____

Phone _____ Guardian (If none, list N/A) _____

Title XIX? ◉ Yes ○ No CIS ID _____ T/RBHA _____ GSA (N/A for T/RBHAs) _____

SMI Provider Name _____ Site Name/Location _____

SMI Case Manager _____ Site Phone _____

SMI Clinical Supervisor _____ Site Fax _____

Indicate the areas of Special Assistance need. Please check all that may apply, regardless of whether a process is currently pending

☐ Service Planning ☐ Discharge Planning Process ☐ Grievance Process ☐ Appeal Process

Provide the clinical basis to support that the person is in need of Special Assistance. Please detail the specific circumstances and how they affect the person's ability to communicate preferences and/or participate effectively in the ISP, discharge planning, grievance/investigation, and/or appeal processes

Grievance or Appeal Pending: ◉ Yes ○ No | Currently Inpatient? ◉ Yes ○ No | Inpatient Facility & Unit _____

Indicate a guardian, relative, or a friend is regularly involved with the person and Behavioral Health provider. ○ Yes ◉ No

If so, by Who (Name) _____ Relationship _____

Phone _____ Address _____ City _____

Is the person in need of Special Assistance aware that you are submitting this notification? ◉ Yes ○ No

Please Explain:

Date Completed _____ By Name _____

Phone Number _____ E-mail _____ Title _____

Last Revised:
Effective date: 10/01/2015

Updated Part B? ○ Yes ○ No

PART B: Response (to be completed by the Office of Human Rights Administration (OHR):

Re: NAME _____ DOB _____ Original Part A Notification Date _____

Per the information provided/supplemental information obtained, the person meets the criteria for Special Assistance ○ Yes ○ No

The person requires Special Assistance in the following areas

☐ Service Planning ☐ Discharge Planning ☐ Grievance Process ☐ Appeal Process

The following person/agency is designated to provide Special Assistance

☐ OHR Assigned Advocate _____ Phone _____

Date (as of) _____

☐ OTHER

First Name _____ Last Name _____ Relationship _____

Address _____ City _____ Phone _____

Additional Information, if any:

Date _____ First Name _____ Last Name _____ OHR Title _____

PART C: Notification of Change (to be completed by the T/RBHA, Provider or other person qualified)

Please indicate the date when the need for Special Assistance was no longer required and the reason(s) why. Submit Part C to OHR within ten (10) days of the determination.

As of, Date _____

The above referenced person no longer meets the criteria for Special Assistance for the following reason(s):

The person was informed, due to a change in circumstances, he/she no longer meets the criteria for Special Assistance and OHR is being notified ○ Yes ○ No

Please explain:

First Name _____ Last Name _____ Agency _____

Phone _____ E-mail _____ Title _____

Date Completed _____