TO:

_____
APPLICANT/MEMBER'S NAME

_____
APPLICANT/MEMBER'S ADDRESS

_____
REPRESENTATIVE'S NAME

_____
REPRESENTATIVE'S ADDRESS

FROM:

_____
NAME OF AGENCY

_____
ADDRESS

_____
CONTACT PERSON/NUMBER

OUR DECISION

This decision concerns:

☐ **YOUR ELIGIBILITY FOR SMI SERVICES**	☐ **YOUR OUTPATIENT OR INPATIENT SERVICE PLAN**
☐ **FEES**	☐ **A CHANGE IN YOUR SERVICES**
☐ **YOUR CLINICAL ASSESSMENT**	☐ **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 [Contractor name] or [Health Plan Name]. 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 serious or immediate threat to your health or safety, or that of another person.

HOW TO GET HELP WITH YOUR APPEAL:

Any adult member or member's legal guardian may represent himself/herself, 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 You may also refer to your member handbook for more information about the appeals process.

_____

NAME OF INDIVIDUAL COMPLETING THIS FORM

_____

SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM

For translation or alternative format requests, call [Contractor insert 1-800 and local number].