VERMONT AGENCY OF HUMAN SERVICES
DEPARTMENT OF MENTAL HEALTH

GRIEVANCES AND APPEALS

Under Vermont's Global Commitment to Health

Designated Agency Provider Manual Addendum

for

Child, Adolescent, and Family Mental Health Programs
Community Rehabilitation and Treatment
Adult Outpatient Programs
Emergency Services

Revised July 2016

Department of Mental Health

Procedures for Grievances and Appeals
Under Vermont's Global
Commitment to Health

Summary of Changes

July 2016	Clarified language around DMH grievance review Clarified role of DA/SSA as MCE regarding children's community services

Department of Mental Health

Procedures for Grievances and Appeals
Under Vermont's Global
Commitment to Health

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ATTACHMENTS

(printable form at **http://mentalhealth.vermont.gov/forms**)

3.5 Client Grievances and Appeals

Introduction to Grievances and Appeals

"Global Commitment" is an 1115(a) Demonstration waiver program under which the federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. The Department of Vermont Health Access (DVHA), as a managed care entity (MCE) under the Global Commitment to Health 1115(a) waiver, is required under 42 C.F.R. Part 438, Subpart F, to have an internal grievance and appeal process for resolving service disagreements between beneficiaries and MCE employees, representatives of the MCE, and state designated agencies, including designated agencies (DAs) and specialized services agencies (SSAs) for mental-health services.

The MCE and any part of the MCE receiving funds for the provision of services under Global Commitment shall be responsible for resolving all grievances and all appeals initiated under these rules.

The designated agency serves as the initial point of response for grievances and appeals. The overall goal of the grievance and appeal process is to resolve disputes fairly, to enhance client and public confidence in the equity and integrity of the service system, to ensure client access to clinically-justified, covered, benefits, and to allow for the independent review of MCE staff decisions concerning appealable actions. Policy on grievances and appeals should be flexible in adapting to client preferences and needs whenever possible. Policy should also state explicitly that any individuals initiating or pursuing a grievance or appeal will be free from any form of retaliation.

Each DA/SSA must appoint a grievances and appeals coordinator who will be responsible for ensuring timely processing and resolution of all grievances and appeals. These positions need not be full-time or dedicated only to one mental-health program.

Proceedings for addressing grievances and making decisions on appeals should be confidential unless the client elects to make grievance issues or appeals public. If the client wishes to make proceedings public, he or she and the DA/SSA must agree upon a method of maintaining the confidentiality of identifying information about any other client who may be identified in connection with grievance issues or appeal proceedings.

Finally, the result of the process shall be clearly communicated to the client and his/her designated representative.

Medicaid recipients are entitled under federal regulation to certain protections with respect to grievances and appeals. The procedures technically apply only to Medicaid recipients. DMH strongly recommends implementation of these procedures for all clients receiving mental-health services from designated agencies.

Definitions

NOTE: Unless otherwise stated, all time frames are stated in calendar days.

The following definitions shall apply:

A. "Action" means an occurrence of one or more of the following by the MCE for which an internal MCE appeal may be requested:
   - denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
   - reduction, suspension or termination of a previously authorized covered service or an MCE approved service plan;
   - denial, in whole or in part, of payment for a covered service;
   - failure to provide a clinically indicated, covered service, when the DA/SSA is acting as the MCE;
   - failure to act in a timely manner when required by state rule;
   - denial of a beneficiary's request to obtain covered services outside the network.

   NOTE: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

   NOTE: Collaborative decisions of any type made by multi-disciplinary groups which include MCE and non-MCE membership such as Local Interagency Teams (LIT), the State Interagency Team (SIT), the State or Local Team for Functionally Impaired, and the Case Review Committee (CRC) are not actions of the MCE and therefore are not eligible for an internal MCE appeal or a fair hearing.

B. "Appeal" means a request for an internal review of an action by the MCE.

C. "Designated Agency/Specialized Service Agency" (DA/SSA) means an agency designated by the Department of Mental Health (DMH) or Department of Disabilities, Aging and Independent Living (DAIL) to provide services and/or service authorizations for eligible individuals with mental-health conditions or developmental disabilities.

D. "Designated Representative" means an individual, either appointed by a beneficiary or authorized under state or other applicable law, to act on behalf of the beneficiary in obtaining a determination or in dealing with any of the levels of the appeal or grievance process. Unless otherwise stated in this rule, the designated representative has all of the rights and responsibilities of a beneficiary in obtaining a determination or in dealing with any of the levels of the appeals process.

E. "Expedited Appeal" means an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

F. "Fair Hearing" means an external appeal that is filed with the Human Services Board, and whose procedures are specified in rules separate from the MCE grievance and appeal process.

G. "Grievance" means an expression of dissatisfaction about any matter that is not an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights.

   If a grievance is not acted upon within the timeframes specified in rule, the beneficiary may ask for an appeal under the definition above of an action as being "failure to act in a timely manner when required by state rule."

   If a grievance is composed of a clear report of alleged physical harm or potential harm, the MCE will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services).

H. "Managed Care Entity" (MCE) means:
   1. The Department of Vermont Health Access (DVHA);
   2. Any state department with which DVHA has an intergovernmental agreement (IGA) under Global Commitment, excluding the Agency of Education, that results in that department's administering or providing services under Global Commitment (i.e. Department for Children and Families; Department of Disabilities, Aging, and Independent Living; Department of Health; Department of Mental Health);
   3. A DA/SSA; and
   4. Any contractor performing service authorizations or prior authorizations on behalf of the MCE.

I. "Network" means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.

J. "Provider" means a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individual's medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that self-manages services is not a provider for purposes of this rule.

K. "Service" means a benefit that is 1) covered under the 1115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services (CMS), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the intergovernmental agreement between the Department of Vermont Health Access and departments of the Agency of Human Services for the administration and operation of the Global Commitment to Health waiver.

L. 3 V.S.A. §3091 (a) - An applicant for or a recipient of assistance, benefits, or social services from the Department for Children and Families, the Department of Vermont Health Access, the Department of Disabilities, Aging, and Independent Living, or the Department of Mental Health, or an applicant for a license from one of those departments or offices, or a licensee, may file a request for a fair hearing with the Human Services Board. An opportunity for a fair hearing will be granted to any individual requesting a hearing because his or her claim for assistance, benefits, or services is denied, or is not acted upon with reasonable promptness; or because the individual is aggrieved by any other agency action affecting his or her receipt of

assistance, benefits or services, or license application; or because the individual is aggrieved by agency policy as it affects his or her situation.

3.6 Grievance Procedures

The DA/SSA shall use a variety of methods to familiarize clients and their representatives with the grievance process. In addition to handbook distribution and an annual review of client rights to promote client awareness of the process, DAs/SSAs shall provide a variety of methods, including an initial rights information orientation, posted notices, periodic staff training, and periodic consumer education to assure that clients and interested persons know about the grievance and appeal processes. DA/SSA staff members should have support and training in identifying issues of concern with a client or his/her representative, various communication and listening skills, negotiation, and mediation.

Administrative Responsibilities

The DA or SSA grievances and appeals coordinator is responsible for all administrative functions related to grievances. The grievances and appeals coordinator will ensure that grievances filed with the DA or SSA are addressed by the appropriate DA or SSA staff person as set out in DA or SSA policies.

DA or SSA responsibilities include the following:

- Acknowledging grievances
- Gathering information
- Writing responses
- Mailing the responses
- Entering data into and managing the MCE Grievances and Appeals database as it applies to the DA or SSA
  Entrance to the database is located at: http://mentalhealth.vermont.gov/about/grievance

Alleged Harm

If a grievance concerns a clear report of alleged physical harm or potential harm, the DA/SSA will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult or Child Protective Services, for example).

All DAs and SSAs must have a clear grievance process consistent with these procedures:

A. Filing Grievances

A grievance may be expressed orally or in writing. A beneficiary or designated representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. Staff members will assist a beneficiary if the beneficiary or his or her representative requests such assistance.

NOTE: A DA/SSA may not require that grievances be put in writing before considering them formal grievances. A DA/SSA is free to make forms available for this purpose, but a beneficiary is not required to complete the form. DA or SSA staff members will assist a client if the client or his or her representative requests assistance in filing a grievance. The DA/SSA will train staff in the practices and procedures to promote prompt informal and formal

resolution of disagreements. Sample forms are included in this packet. (See Attachment 3.D, DA/ SSA Grievance or Appeal Form and Attachment 3.E, Grievance Process Flow Chart)

B. Written Acknowledgement

Written acknowledgment of the grievance must be mailed within 5 days of receipt by the MCE. The acknowledgement must be made by the part of the MCE responsible for the service area that is the subject of the grievance. If the MCE decides the issue within the five-day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases. (See Attachment 3.F, Sample DA/SSA Grievance Acknowledgment Letter, page 20) The DA/SSA is responsible for seeing that a copy of the letter of acknowledgment is uploaded to the database.

The DA or SSA grievances and appeals coordinator has responsibility for acknowledging all grievances. Copies will be sent to the client (and his or her designated representative, if applicable).

C. Withdrawal of Grievances

Beneficiaries or their designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the MCE in writing within five calendar days. (See Attachment 3.G, Sample DA/SSA Letter Acknowledging Oral Withdrawal of Grievance/Appeal/Request for Fair Hearing, page 21).

D. Disposition

All grievances shall be addressed within 90 days of receipt. The decision-maker must provide the beneficiary with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the notice must also inform the beneficiary of his or her right to initiate a grievance review with the MCE as well as information on how to initiate such review (See Attachment 3.H, Sample DA/SSA Grievance Response, page 22).

E. Grievances Filed After 60 Days

DAs/SSAs are not required to proceed on grievances that are not filed within the specified time frame of 60 days. See Attachment 3.I, Sample DA/SSA Letter Responding to Grievance Filed Late, page 23.

3.7 DMH Involvement in the Client Grievance Process

Receipt of ***Unresolved*** Grievances by MCE

An unresolved grievance is one that has not gone through the DA/SSA grievance process at the DA/SSA level. DMH encourages clients to use the grievance and appeal process at the DA/SSA. The DA/SSA and the client and/or representative are expected to complete the grievance process, and the DA/SSA is expected to address the grievance within the grievance time lines specified. Unresolved grievances received by DMH will be acknowledged in writing to both the client and the DA/SSA within five calendar days of receipt. This notification shall cause the local DA/SSA grievance process

to begin. DMH will see that the information is entered into the MCE Grievance and Appeal database and assign the case to the DA/SSA grievance and appeal coordinator.

Grievance Reviews

1. Filing a Grievance Review - If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by the Department of Mental Health within 10 calendar days of the decision (See Attachment 3.J, Sample DMH Grievance Review Request Form Letter for Use by Clients, page 24).

2. Written Acknowledgment - The Department of Mental Health will acknowledge grievance review requests within 5 calendar days of receipt.

3. Disposition - DMH will review the merits of the grievance issue(s), the process employed by the DA/SSA in reviewing the issue(s), and the information the DA/SSA considered in making its determination. *The primary purpose of the DMH grievance review shall be to ensure that the grievance process is functional and resolution impartial, rather than reversing a DA/SSA grievance resolution.* If it is found that the process was not followed and/or not impartial, DMH has the authority to reverse the decision and/or establish a corrective action plan with the DA/SSA. The beneficiary will be notified in writing of the findings of the grievance review within 90 days. The DMH grievance review determination is considered final.

Fair Hearing

Although the disposition of a grievance is not subject to a fair hearing before the Human Services Board, the beneficiary may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V.S.A. §3091 (a) (See Definitions Section).

Copies of the disposition will be sent to the client and his or her designated representative if applicable.

Data Documentation

Data on all grievances and appeals will be documented in the Grievance and Appeals database, as will Fair Hearing requests and outcomes for those cases. The MCE Grievance and Appeals Coordinator at the Department of Vermont Health Access (DVHA) will maintain the database. All related correspondence and other pertinent documentation must be maintained in individual client files in the DA/SSA and be retrievable for audits and reviews by the MCE or other authorized entity.

3.8 Appeal Procedures

MCE or Provider Status

If Provider "Actions" are in:

CRT Program	DA is an MCE
CRT Hospitalization	Hospitals are Providers (See Participating Provider Decisions)
Adult Outpatient Program	DA is Provider (See Participating Provider Decisions)
Emergency Services Program	DA is Provider (See Participating Provider Decisions)
Child, Youth and Family Community Services	DA/SSA is Provider (See Participating Provider Decisions) (note: excludes children's Enhanced Family Treatment)
• Children's Enhanced Family Treatment (EFT) Services • Children's E-bed extensions • Children's residential assessment and treatment (PNMI)	DMH is MCE and performs Appeal Reviews DA/SSA is Provider and performs Grievance Reviews (PNMI has separate process under licensing)

DAs and SSAs must establish and maintain their own internal procedures for internal review of appeals consistent with the requirements outlined in this Provider Manual Addendum. The appeal procedures must be available to all interested persons. An "interested person" includes the client and/or the client's authorized representative and any person the client appoints (verification of the appointment of an "interested person" is the responsibility of the MCE entity—DA, SSA, or DMH—receiving the appeal). This may include the client's family members and referring service providers acting on the client's behalf.

A. Right to Appeal

Beneficiaries may request an internal MCE appeal of an MCE action, and a fair hearing before the Human Services Board. A beneficiary may utilize the internal MCE appeal process while a fair hearing is pending or before a fair hearing is requested, except when a benefit is denied, reduced, or eliminated as mandated by federal or state law or rule. When denial, reduction, or elimination of a benefit is so mandated, the beneficiary cannot use the MCE appeal process and would challenge the decision only by requesting a fair hearing.

B. Request for Non-Covered Services

An MCE appeal under this rule may only be filed regarding the denial of a service that is covered under Medicaid. Any request for a non-covered service must be directed to DVHA under the provisions of the Medicaid rules at 7104. A subsequent DVHA denial under 7104 to cover such service cannot be appealed using the appeal process set forth in this rule, but may be appealed through the fair hearing process.

C. Medicaid Eligibility and Premium Determinations

If a beneficiary files an MCE appeal regarding only a Medicaid eligibility or premium determination, the entity that receives the appeal will forward it to the Department for Children and Families (DCF), Economic Services Division. The entity that received the appeal

originally will then notify the beneficiary in writing that the issue has been forwarded to and will be resolved by DCF. These appeals will not be addressed through the MCE appeal process and will be considered a request for fair hearing as of the date the MCE received it (See Attachment 3.K, Sample DA/SSA Letter Informing Client That Appeal Has Been Forwarded to Another Department for Resolution, page 25).

D. Filing of Appeals

Beneficiaries may file appeals orally or in writing for any MCE action. Providers and representatives of the beneficiary may initiate appeals only after a clear determination that the third-party involvement is being initiated at the beneficiary's request. Appeals of actions must be filed with the MCE within 90 days of the date of the MCE notice of action. The date of the appeal, if mailed, is the postmark date (See Attachment 3.D, DA/SSA Grievance or Appeal form, page 18). If a client waits longer than 90 days to file an appeal, the DA/SSA does not have to proceed (See Attachment 3.Q, Sample DA/SSA Letter in Response to an Appeal Filed After 90 Days, page 32).

The MCE appeal process will include assistance by staff members of the MCE, as needed, for the beneficiary to initiate and participate in the appeal. If a beneficiary requests assistance of a DA/SSA for an appeal where DMH is the MCE, DA/SSA staff may provide this assistance or immediately notify DMH of the request for assistance and contact information for the individual requesting assistance. Beneficiaries may also call the Office of the Health Care Advocate at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

E. Written Acknowledgment

Written acknowledgement of the appeal shall be mailed within 5 days of receipt by the part of the MCE that receives the appeal (See Attachment 3.L, Sample DA/SSA Appeal Letter Acknowledging Appeal, page 26, and Attachment 3.M, Appeal Process Flow Chart, page 27).

If a beneficiary files an appeal with the wrong entity, that entity will notify the beneficiary in writing in order to acknowledge the appeal. This written acknowledgement shall explain that the issue has been forwarded to the correct part of the MCE, identify the part to which it has been forwarded, and explain that the appeal will be addressed by that part. This does not extend the deadline by which appeals must be determined (See Attachment 3.K, Sample DA/SSA Letter Informing Client That Appeal Has Been Forwarded to Another Department for Resolution, page 25).

F. Withdrawal of Appeals

Beneficiaries or designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the MCE in writing within 5 days (See Attachment 3.G, Acknowledgment of Oral Withdrawal of a Grievance/Appeal/Request for Fair Hearing, page 21).

G. Beneficiary Participation in Appeals

The beneficiary, his or her designated representative, or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person, by phone or in writing in the meeting in which the MCE is considering the final decision regarding an appeal. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. Beneficiaries, their designated representative, or treating provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to have a material effect on the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting.

Upon request, the MCE shall provide the beneficiary or his/her designated representative with all the information in its possession or control relevant to the appeal process and the subject of the appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The MCE will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.

H. MCE Appeals Reviewer

The individual who hears the appeal shall not have made the decision subject to appeal and shall not be a subordinate of the individual who made the original decision. Appeals shall be decided by individual(s) designated by the entity responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possesses requisite clinical expertise, as determined by the MCE, in treating the beneficiary's condition or illness.

I. Resolution

Appeals shall be decided and written notice sent to the beneficiary within 45 days of receipt of the appeal. The beneficiary shall be notified as soon as the appeal meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a meeting cannot be scheduled so that the decision can be made within the 45-day time limit, the time frame may be extended up to an additional 14 days, by request of the beneficiary or by the MCE if the extension is in the best interest of the beneficiary. If the extension is at the request of the MCE, it must give the beneficiary written notice of the reason for the delay. The maximum total time period for the resolution of an appeal, including any extension requested either by the beneficiary or the MCE, is 59 days. If a meeting cannot be scheduled within these time frames, a decision will be rendered by the MCE without a meeting with the beneficiary, the designated representative, or treating provider (See Attachment 3.N, Sample DA/SSA Letter Informing Client of Favorable Internal Review of Appeal, page 28, and Attachment 3.O, Sample DA/SSA Letter Informing Client of Adverse Internal Review of Appeal, page 29).

NOTE: Appeals on CRT Program Actions. A DA will notify DMH of any appeal of a CRT Program action and provide all correspondence, either electronically or via fax transmittal, and any information considered in the initial action and internal review related to an adverse appeal resolution. This information will be necessary if there is a request for a Fair Hearing. At any point in the appeal process, a DA may consult with DMH regarding a program action or request DMH involvement in determining a resolution decision.

NOTE: Appeals on Children's Enhanced Family Treatment Services, Children's e-bed extensions, and Children's Residential Assessment & Treatment (PNMI) Actions. The Child, Adolescent, and Family Unit (CAFU) within DMH retains MCE authorization for child Enhanced Family Treatment (EFT) services, e-bed extensions and residential assessment and treatment. Following a request for these services and adverse decision by CAFU, a request for appeal to the MCE is the responsibility of DMH. CAFU as the MCE will follow beneficiary notice and appeals procedures outlined in this Provider Manual Addendum for these service appeals. Further elaboration of the procedures can be found in the Enhanced Family Treatment Services Manual or the Case Review Committee Guidelines and Procedures (for residential).

J. Expedited Appeal Requests

Expedited appeals may be requested in emergent situations in which the beneficiary or the treating provider (in making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the MCE for any MCE actions subject to appeal. The MCE will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal.

If the request for an expedited appeal is denied because it does not meet the criteria, the MCE will inform the beneficiary that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45-day time frame. An oral notice of the denial of the request for an expedited appeal must be promptly communicated (within 2 days) to the beneficiary and followed up within 2 days of the oral notification with a written notice (See Attachments 3.R and 3.S for DA/SSA Sample Letters Approving/Denying a Request for an Expedited Appeal, pages 33 and 34).

If the expedited appeal request meets the criteria for such appeals, it must be resolved within 3 working days. If an expedited appeal cannot be resolved within 3 working days, the time frame may be extended up to an additional 14 days by request of the beneficiary, or by the MCE if the extension is in the best interest of the beneficiary. If the extension is at the request of the MCE, it must give the beneficiary written notice of the reason for the delay. An oral notice of the expedited appeal decision must be promptly communicated (within 2 days) to the beneficiary and followed up within 2 days of the oral notification with a written notice. The written notice for any expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the beneficiary's right to request a fair hearing if not already requested.

Participating Provider Decisions

Provider decisions shall not be considered MCE actions and are not subject to appeal using this process.

A state agency shall be considered a provider if it provides a service that:

1. is claimed at the Medicaid service matching rate;
2. is based on medical or clinical necessity; and
3. does not have prior authorization.

Designated Agencies(DA)/Specialized Service Agencies(SSA)/Hospitals are providers when their decisions do not affect beneficiary eligibility or services. In the case of Adult and Children's Outpatient services and Emergency Services, a DA/SSA/Hospital action does not affect a beneficiary's eligibility to receive these services by another Medicaid provider. The only actions that may be appealed are those that effectively deny or limit eligibility or access to a service and must be authorized by the MCE.

Notices, Continued Services, and Beneficiary Liability

A. Beneficiary Notice

The part of the MCE issuing a services decision that meets the definition of an action must provide the beneficiary with written notice of its decision. In cases involving a termination or reduction of service(s), such notice of decision must be mailed at least 11 days before the change will take effect. When the decision is adverse to the beneficiary, the notice must inform the beneficiary when and how to file an appeal or fair hearing. In addition, the notice must inform the beneficiary that he or she may request that covered services be continued without change as well as describe the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any MCE appeal or fair hearing. DAs/SSAs must have and use a notice that meets legal requirements for Medicaid notices (See Attachment 3.P, Sample Service Change Notification Form, pages 30).

B. Continuation of Services

1. If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered service termination, suspension, or reduction under the following circumstances:
   a. the MCE appeal was filed in a timely manner, meaning before the effective date of the proposed action;
   b. the beneficiary has paid any required premiums in full;
   c. the appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan; and
   d. the services were ordered by an authorized provider and the original period covered by the authorization has not expired.

2. If properly requested, a service must be continued until any one of the following occurs:
   a. the beneficiary withdraws the appeal;
   b. any limits on the cost, scope or level of service, as stated in law or rule, have been reached;
   c. the MCE issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing within the applicable time frame;
   d. a fair hearing is conducted and the Human Services Board issues a decision adverse to the beneficiary; or
   e. the time period or service limits of a previously authorized service have been met.

Beneficiaries may waive their right to receive continued benefits pending appeal.

C. Change in Law

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law or rule affecting some or all beneficiaries, or when the decision does not require the minimum advance notice.

D. Beneficiary Liability for Cost of Services

A beneficiary may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

The MCE may recover from the beneficiary the value of any continued benefits paid during the appeal period when the beneficiary withdraws the appeal before the relevant MCE or fair hearing decision is made, or following a final disposition of the matter in favor of the MCE. Beneficiary liability will occur only if an MCE appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCE also determines that the beneficiary should be held liable for service costs.

If the provider notifies the beneficiary that a service may not be covered by Medicaid, the beneficiary can agree to assume financial responsibility for the service. If the provider fails to inform the beneficiary that a service may not be covered by Medicaid, the beneficiary is not liable for payment. Benefits will be paid retroactively for beneficiaries who assume financial responsibility for a service and who are successful on such service coverage appeal.

E. Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, the MCE is not required to initiate service delivery.

The MCE is not required to provide a new service or any service that is not a Medicaid-covered service while a fair hearing determination is pending.

3.9 Fair Hearing

Clients receiving mental-health services from DAs and SSAs also have the right to file requests for Fair Hearings related to program eligibility determinations and reductions or denials of mental-health services if:

- they are enrolled in Medicaid and
- actions pertain to the CRT Program OR
- actions pertain to children's Enhanced Family Treatment services, Children's e-bed extensions, and Children's Residential Assessment & Treatment (PNMI)

A client may make a request for a Fair Hearing within 30 days of receipt of the adverse appeal decision (See Attachment 3.T, Sample Client Request for a Fair Hearing, page 35). As referenced in Notices, Continued Services, and Beneficiary Liability, provisions for the continuation of services and potential beneficiary liability pending the outcome of a Fair Hearing continue to apply.

The DA/SSA must cooperate with DMH and the DMH Legal Unit in preparation of necessary documentation for Fair Hearing. The DA/SSA will prepare and submit any medical/clinical records and other documentation pertinent to the proceedings of a Fair Hearing before the Human Services Board. The DMH Legal staff shall represent the State in any Fair Hearings pertaining to determinations of eligibility for CRT program or services and Children's Services for youth experiencing a severe emotional disturbance and their families. The DA/SSA should arrange for its own legal representation.

A status conference will be held initially with a Hearing Officer prior to Fair Hearing. The DMH Legal Division will review the merits of the request for Fair Hearing considering the client's Medicaid eligibility status and Medicaid coverage for the services under appeal. Depending on the information provided at the status conference, the Fair Hearing may move forward and an advisory opinion may be offered to the Human Services Board. The Human Services Board will issue a Final Order to the Secretary of the Agency of Human Services (AHS). The AHS Secretary then has 10 days to accept the Human Services Board's order or request a reversal of the order. DMH and the DA/SSA must comply with the final determination.

ATTACHMENT 3.D

DA/SSA GRIEVANCE OR APPEAL FORM

If you are dissatisfied with your agency, a member of its staff, or decisions about services that you receive, you may complete this form and give it to the agency's grievances & appeals coordinator so that issues can be resolved reasonably quickly. This form is made available for your convenience, but you may write your concerns down in any way you choose. Or, if you prefer, you may talk to the grievances & appeals coordinator about your concerns.

- ***We encourage you to express your dissatisfaction openly.***
- ***Your concerns are considered confidential.***
- ***Your services will not be affected if you file a grievance or appeal an action.***
- ***No staff member will treat you poorly if you express your concerns.***
- ***You are entitled to an agency decision regarding your concerns and reasons for the agency's decision.***

Name: _____ (required in order to provide a response)

Address: _____ or e-mail _____

Telephone #: _____ (*if preferred*) Date: _____

(X) What best describes your concerns? If your concerns are about a denial, reduction, or stoppage of service, please give as much detail as possible. If your concerns are about the agency or staff, please describe the issues.

The following categories may help, but you are not limited to this list:

Examples of Grievance Issues:	Examples of Appeal Issues:
1. ☐ Dissatisfaction with a staff/contractor 2. ☐ Dissatisfaction with management 3. ☐ Dissatisfaction with program decision 4. ☐ Dissatisfaction with policy decision 5. ☐ Dissatisfaction with quality of services 6. ☐ Dissatisfaction with accessibility of services 7. ☐ Dissatisfaction with timeliness of response 8. ☐ Dissatisfaction with services not offered or not available	1. ☐ Denial or limited authorization of a requested covered service. 2. ☐ Reduction, suspension, or termination of an authorized service or service plan 3. ☐ Denial, in whole or in part, of payment for a service 4. ☐ Failure to provide services in a timely manner 5. ☐ Failure to provide clinically indicated covered services 6. ☐ Denial of request for covered services outside Medicaid network

Describe your concerns and what steps you have taken to resolve the problem so far. _____

_____

_____

How would you like to see the problem resolved? _____

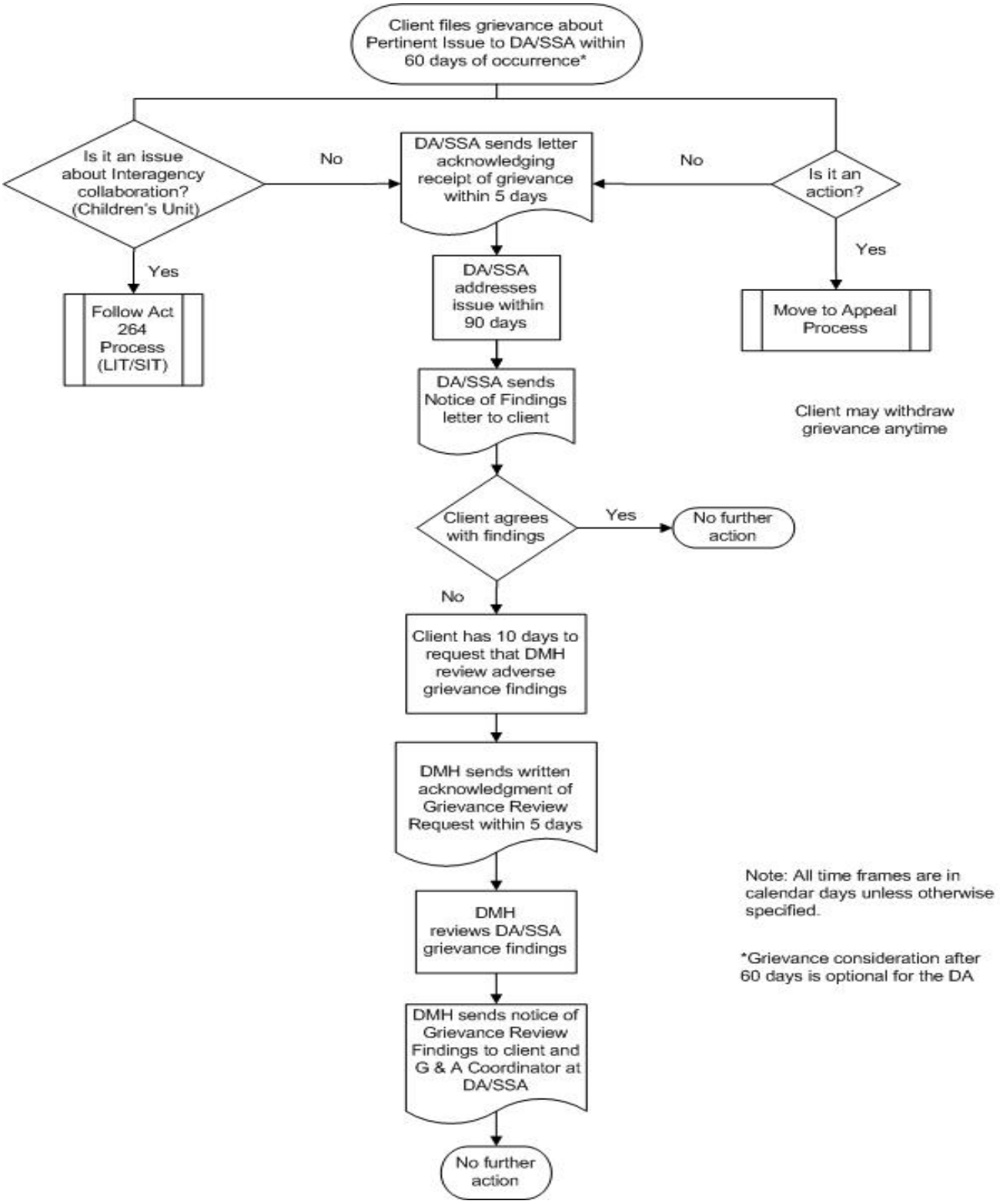
_____

_____

_____

ATTACHMENT 3.E

GRIEVANCE PROCESS FLOW CHART



ATTACHMENT 3.F

SAMPLE DA/SSA GRIEVANCE ACKNOWLEDGMENT LETTER

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We have received your grievance about:
[GRIEVANCE ISSUE]

We will look into your grievance and mail you a letter by [GRIEVANCE DUE DATE: 90 calendar days from receipt of client's grievance].

If you have any questions, please feel free to call me at [local phone number] or [toll-free number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

[NAME OF STAFF]
[DA] Grievance and Appeal Coordinator

copy to: DVHA Electronic Data File
DA File

ATTACHMENT 3.G
SAMPLE DA/SSA LETTER ACKNOWLEDGING ORAL WITHDRAWAL OF GRIEVANCE/APPEAL/REQUEST FOR FAIR HEARING

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We have received your oral verbal request to withdraw your request for a [GRIEVANCE/APPEAL/FAIR HEARING]. We will stop looking into your grievance/appeal about [GRIEVANCE/APPEAL ISSUE].

Thank you for contacting us. If you have any further questions, please feel free to call me, at [local phone number] or [toll-free number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to:DVHA Electronic Database
DA File

ATTACHMENT 3.H
SAMPLE DA/SSA GRIEVANCE RESPONSE

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We have reviewed the grievance you filed on [DATE] about [GRIEVANCE ISSUE]. Here is what we found. [INSERT RESULTS]

If you are not satisfied with this response you may ask for a **grievance review** by the Department of Mental Health (DMH) within the next 10 calendar days. In a grievance review DMH will take another look at your grievance, how we addressed it and the information we considered in making our decision.

If you want to ask for a grievance review, you should take one of the following actions within ten calendar days from the date of this letter.

- Tell me either verbally or in writing that you want DMH to review our response to your grievance,

OR

- Tell the DMH either verbally or in writing that you want DMH to review the agency's response to your grievance. You may telephone the DMH at (802) 241-0090 or (888) 212-4677. You may mail a letter to the DMH at 280 State Drive, NOB 2 North, Waterbury, VT 05671-2010. If you have additional information to offer at this time, please send the information to the DMH as well.

If you have questions, please call me at [local phone number] or [toll-free number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to: DVHA Electronic Data Base
DA File (follow DA policy/procedure for handling of hard copy)

ATTACHMENT 3.I
SAMPLE DA/SSA LETTER RESPONDING TO GRIEVANCE FILED LATE

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your request to file a grievance on [DATE] for [GRIEVANCE ISSUE].

Requests for grievance investigations regarding issues that occurred more than 60 days ago are not considered for further action. Since your grievance issue is beyond this time frame, we are unable to proceed with addressing this grievance.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to: DVHA Electronic Data File
DA File

ATTACHMENT 3.J
SAMPLE DMH GRIEVANCE REVIEW REQUEST
FORM LETTER FOR USE BY CLIENTS

[DATE]
[CLIENT ADDRESS]
[CITY, VT ZIP]

Vermont Department of Mental Health
DMH Quality Management Coordinator
280 State Drive NOB 2 North
Waterbury, VT 05671-2010

Dear DMH [Adult or Child] Quality Management Coordinator:

I do not agree with how [NAME OF DA] addressed my grievance about [DESCRIBE THE GRIEVANCE] for the following reason/s [TELL THE REASONS YOU DO NOT AGREE IT WAS THE RIGHT DECISION].

- I received the decision on [DATE YOU WERE NOTIFIED].*Client should make request within 10 calendar days for grievance review by the Department of Mental Health.*

I would like a GRIEVANCE REVIEW by DMH.

- *DMH will see if the grievance process was followed and the decision made with adequate information. The DMH grievance review is considered final. Clients may also request a Fair Hearing of a grievance issue before the Human Services Board, but generally Fair Hearings are reserved for appeals of actions related to reduction, suspension, or denial of service.*

Sincerely,
CLIENT NAME]

Copy:

- *People you might want to send copies of your grievance review request:*
  DA Grievance and Appeal Coordinator
  DA CRT Director
  DA Executive Director
  Disability Rights Vermont (DRVT)
  Vermont Psychiatric Survivors

ATTACHMENT 3.K
SAMPLE DA/SSA LETTER INFORMING CLIENT THAT APPEAL HAS BEEN FORWARDED TO ANOTHER DEPARTMENT FOR RESOLUTION

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your appeal request about [APPEAL ACTION]. We are not the agency to decide this appeal. We are not able to decide appeals [about ELIGIBILITY FOR HEALTH CARE PROGRAMS and/or PREMIUMS YOU SHOULD PAY **OR** NOT THE PROPER AGENCY TO DECIDE THIS APPEAL].

We have forwarded your appeal to [Economic Services Division of the Department for Children and Families **OR** Proper Agency] because they decide these appeals. You will hear from them soon.

If you have any questions, please feel free to call [DCF-ESD Coordinator **OR** OTHER AGENCY COORDINATOR] at [phone number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to: DA File
[name],[DCF-ESD or Other Agency] Grievance & Appeal Coordinator

ATTACHMENT 3.L
SAMPLE DA/SSA LETTER ACKNOWLEDGING APPEAL

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS1]
[CLIENT ADDRESS2]
[CITY], [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your appeal filed on [DATE] about [ACTION]. We will begin an internal review of our action. You will be contacted by a supervisor in our agency who was not involved in the original action and who is qualified to consider your appeal. An appeal meeting will be scheduled to hear any new information related to your appeal.

The entire process for an appeal should not take longer than 45 days from the date you filed your appeal at this agency, but it could take another 14 days if more time will help you.

You also have the right to ask for a Fair Hearing with the Human Services Board at any time throughout the appeal process up until 30 days after the appeal resolution decision. To ask for a Fair Hearing, telephone the Human Services Board at (802) 828-2536 or mail a letter to 118 State Street, Drawer 20, Montpelier, VT 05620-4301.

If you request continuation of services under appeal, the [DA/SSA] is required to inform you that you may be liable for the cost of services that are continued during the appeal process. You will be liable only if our decision on your appeal and/or a Fair Hearing upholds [DA/SSA's] action and also determines that you should be held liable for service costs.

If you have any questions about your appeal, you may contact me at [local phone number] or [toll-free number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays. You may send any additional or new information you have about your appeal to my attention.

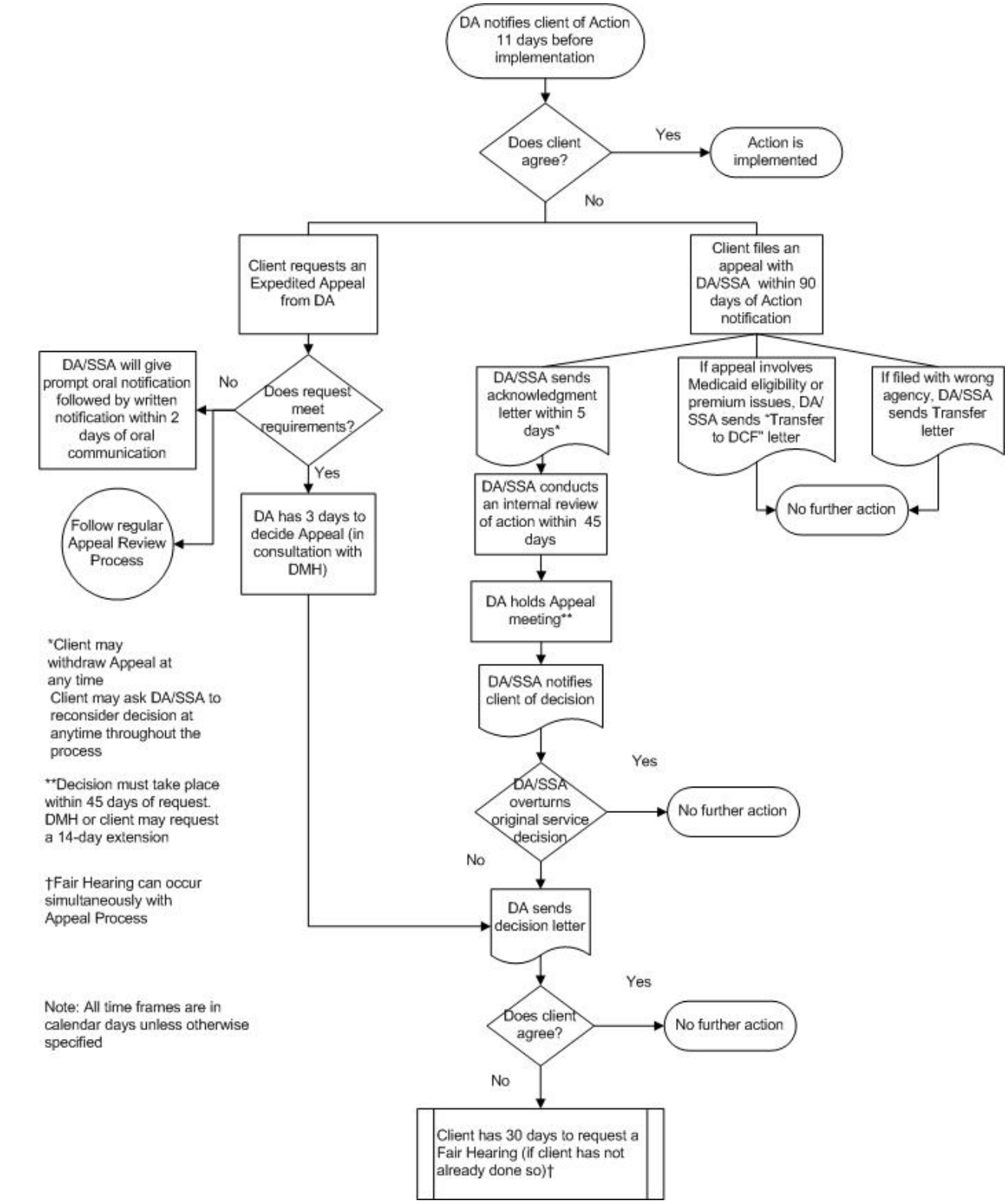
The Office of the Health Care Advocate can also help you with appeals. The telephone number there is 1-800-917-7787.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to: DVHA Electronic Data File
DA File
DMH [Adult (if CRT Program) or Child (if Child Program)] Mental Health Director

ATTACHMENT 3.M
APPEAL PROCESS FLOW CHART



ATTACHMENT 3.N
SAMPLE DA/SSA NOTICE OF FAVORABLE INTERNAL REVIEW OF APPEAL

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

Your appeal request filed on [DATE] for [APPEAL ACTION] has been ***approved***.

Your appeal was approved for the following reasons:

If you have any questions, please feel free to call me at [local phone number] or [toll-free number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to: DVHA Electronic Data File
DA File
DMH [Adult (if CRT Program) or Child (if Child Program)] Mental Health Director

ATTACHMENT 3.O
SAMPLE DA/SSA NOTICE OF ADVERSE INTERNAL REVIEW OF APPEAL

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We have completed the internal review of your appeal filed on [DATE] about [ACTION APPEALED]. We reviewed your appeal in the following manner [DESCRIBE THE PROCESS, including who heard the appeal, the meeting date, and who was present at meeting]. Based on [DESCRIBE THE INFORMATION PRESENTED AND CONSIDERED IN MAKING THE DECISION], we have decided that our action was appropriate because [TELL REASONS].

You have the right to ask for a Fair Hearing with the Human Services Board up until 30 days after this notification of decision on your appeal. To ask for a Fair Hearing, telephone the Human Services Board at (802) 828-2536 or mail a letter to 118 State Street, Drawer 20, Montpelier, VT 05620-4301.

If you request continuation of services under appeal, the [DA/SSA] is required to inform you that you may be liable for the cost of services that are continued during the Fair Hearing process. You will be liable only if the Fair Hearing upholds [DA/SSA's] action and also determines that you should be held liable for service costs.

If you have any additional questions, please feel free to call me at [local phone number] or [toll-free number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

The Office of the Health Care Advocate can help you with Fair Hearings, too. The telephone number there is (800) 917-7787.

Sincerely,

Staff Name
[DA] Grievance and Appeal Coordinator

copy to: DVHA Electronic Data File
DA File
DMH [Adult (if CRT Program) or Child (if Child Program)] Mental Health Director

ATTACHMENT 3.P
SAMPLE SERVICE CHANGE NOTIFICATION FORM

Your treatment team plans the following change in your [Program] Services given your current treatment needs:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Date of Notice:_____

Staff Name:_____**Staff Signature:** _____

Client Name:_____**Client Signature**:_____

____*Check if he/she refused to sign*

You have the following rights available to you if you disagree with this planned treatment change.

- If you do not agree with the plan, you may appeal the DA action.
- You have up to 90 days from the date of this notice to request an appeal. If you request an appeal after 90 days, the agency may or may not choose to consider your appeal.
- If you file an appeal before these changes take effect, and you request a continuation of services, your services will not be changed until your appeal is resolved. If you file an appeal after these changes take effect, services will continue as changed while your appeal is being resolved.
- Your appeal must be resolved within 45 days from the date of your appeal, unless an extension of no more than 14 additional days to resolve the appeal is needed. The [AGENCY] will notify you of the results of its internal review of your appeal.
- You may make a request for a Fair Hearing at any time throughout the appeal process until 30 days after the decision notification on your appeal. If you request a Fair Hearing after 30 days from decision notification, your rights to a Fair Hearing may be affected.

- If your appeal goes to a Fair Hearing and your appeal is upheld, the [AGENCY] must provide the mental-health services outlined in the current treatment plan.

If you need more information about appeals or assistance in asking for an appeal or fair hearing, you can contact the following people or agencies for help:

- ❖ The grievance and appeals coordinator at the DA/SSA

(Insert local name and contact information)

- ❖ The Department of Mental Health at (802) 241-0090; or, for the State of Vermont only, call our toll-free number: 1-888-212-4677; TTY Relay Service at 1-800-253-0191; or by mail to DMH, 280 State Drive, NOB 2 North, Waterbury, VT 05671-2010

- ❖ Office of the Health Care Advocate at 1-800-917-7787 **or by mail at** P.O. Box 1367, 264 N. Winooski Avenue, Burlington, Vermont 05402

- ❖ Disability Rights Vermont at 1-802-229-1355 or by mail at 141 Main Street, Suite 7, Montpelier, VT 05602

- ❖ Vermont Psychiatric Survivors at 1-800-564-2106 or by mail at 1 Scale Avenue, Suite 52, Rutland, VT 05701

To Request a Fair Hearing at any time, write to:

Human Services Board
118 State Street
Drawer 20
Montpelier, VT 05602

or call: 802-828-2536.

copy to: DA File

ATTACHMENT 3.Q
SAMPLE DA/SSA LETTER IN RESPONSE TO APPEAL FILED AFTER 90 DAYS

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your request to file an appeal on [APPEAL DATE]. Unfortunately, you did not request this appeal within 90-days of [AGENCY] appeal decision notification. Since your request for an appeal has exceeded this time frame, we will not consider this appeal. You have also exceeded the time frame to file a request for a Fair Hearing.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to: DA File
DVHA Electronic Data File

ATTACHMENT 3.R
SAMPLE DA/SSA LETTER APPROVING REQUEST FOR EXPEDITED APPEAL

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your emergency (expedited) appeal request for [APPEAL ACTION].

We agree that this request meets expedited criteria and will proceed to resolve your appeal within 3 working days. The time frame may be extended up to an additional 14 days by request of the beneficiary or by the Managed Care Entity (MCE) if the extension is in the best interest of the beneficiary. You will also receive a new [Service Change Notification Form].

If you have any questions, please feel free to call me at [local phone number] or [toll-free number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to: DA File
DVHA Electronic Data File

ATTACHMENT 3.S
SAMPLE DA/SSA LETTER DENYING REQUEST FOR EXPEDITED APPEAL

DA/SSA LETTERHEAD

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

[DATE]

[CLIENT NAME]
[CLIENT ADDRESS 1]
[CLIENT ADDRESS 2]
[CITY] [STATE] [ZIP]

Dear [CLIENT NAME]:

We received your emergency (expedited) appeal request for [APPEAL ACTION].

Based on the information we have, we **do not agree** that taking 45 days to decide your appeal could seriously risk your life, health or ability to attain, maintain, or regain maximum function.

Your appeal will now be decided in the standard 45-day time frame. Your appeal should be decided by [DUE DATE]. This time frame may be extended by 14 days if needed. We will notify you of the appeal meeting date.

If you have any questions, please feel free to call me at [local phone number] or [toll-free number] Monday through Friday, 7:45 a.m. to 4:30 p.m., except holidays.

Sincerely,

[Staff Name]
[DA] Grievance and Appeal Coordinator

copy to:DVHA Electronic Data File
DA File
DMH [Adult (if CRT Program) or Child (if Child Program)] Mental Health Director

ATTACHMENT 3.T
SAMPLE CLIENT REQUEST FOR A FAIR HEARING

Client's Address (Street or PO Box #)
City, State ZIP Code
Date

Human Services Board
118 State Street
Drawer 20
Montpelier, VT 05602

Dear Human Services Board:

I do not agree with how [DA/SSA] resolved my appeal about [DESCRIBE WHAT SERVICE WILL BE OR HAS BEEN DENIED, REDUCED, OR SUSPENDED BY THE DA].

[TELL THE REASONS YOU DO NOT AGREE IT WAS THE RIGHT DECISION REGARDING YOUR TREATMENT].

Additional comments or clarifying information.

I received the decision on [DATE YOU WERE NOTIFIED BY DA/SSA].

You should make your request within 90 days of the original DA action notice or within 30 days of the DA appeal decision.

I would like a FAIR HEARING with the Human Services Board.

Sincerely,

[YOUR NAME]

Copy: *People to whom you <u>should</u> send copies of the Fair Hearing request:*
DA grievance and appeals coordinator
DMH
Your attorney