



DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

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NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

[_____]
[_____]
[_____]
[_____]

Tri-City Mental Health Services
[_____]

RE: Specialty Mental Health Services (SMHS)

This notice lets you know that **the Los Angeles County Mental Health Plan (the Plan)** has determined that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services **under the California Code of Regulations (CCR).**

Per our assessment:
Select one of the following reasons for Outpatient Services

Outpatient Services:

Your mental health diagnosis, if any, is not covered for SMHS under CCR Title 9 Section 1830.205 (b)(1).

Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for SMHS under CCR Title 9 Section 1830.205 (b)(2).

SMHS are not likely to help you by improving or preventing the worsening of your mental health condition per CCR Title 9 Section 1830.205 (b)(3)(A)(B).

Your mental health condition would be responsive to treatment by a physical health care provider per CCR Title 9 Section 1830.205 (b)(3)(C).

As an Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) eligible beneficiary, SMHS are not likely to correct or ameliorate your mental health condition per CCR Title 22 Section 51340 (e)(3)(A).

Enter additional information if needed:

Although you do not qualify for specialty mental health services, you may be able to receive non-specialty mental health services from _____.
(Enter: Health Plan or Entity Responsible)

You can call them at _____.
(Enter: Health Plan Phone Number)

You may appeal this decision if you think it is incorrect. The enclosed “Your Rights” information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed “Your Rights” information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call **the Plan** at **(800) 700-9996**.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within **10 days** from the date on this letter, or before the date your mental health plan says services will be stopped or reduced.

The Plan can help you with any questions you have about this notice. For help, you may call **the Plan Monday through Friday between 8:30 a.m. and 5:00 p.m. PST at (800) 700-9996**. If you have trouble speaking or hearing, please call TTY/TTD number **(562) 651-2549 anytime** for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact **the Los Angeles County Mental Health Plan (the Plan)** by calling **(800) 700-9996**.

If the Plan does not help you to your satisfaction and/or you need additional help, the **State Medi-Cal Managed Care Ombudsman Office** can help you with any questions. You may call them **Monday through Friday, 8:00 am to 5:00 pm PST**, excluding holidays, at **1-888-452-8609**.

This notice does not affect any of your other Medi-Cal services.

[_____]
[_____]
[_____]

Tri-City Mental Health Services

Enclosed: “Your Rights”
Language Assistance
Beneficiary Non-Discrimination Notice

YOUR RIGHTS UNDER MEDI-CAL

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact **DMH ACCESS Center** by calling **800-854-7771**.

IF YOU DO NOT AGREE WITH THE DECISION MADE FOR YOUR MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT, YOU CAN FILE AN APPEAL. THIS APPEAL IS FILED WITH YOUR PLAN.

HOW TO FILE AN APPEAL

You have **60 days** from the date of this “Notice of Adverse Benefit Determination” letter to file an appeal. **If you are currently getting treatment and you want to keep getting treatment, you must ask for an appeal within 10 days** from the date on this letter OR before the date your Plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

You can file an appeal by phone or in writing. If you file an appeal by phone, you must follow up with a written signed appeal. The Plan will provide you with free assistance if you need help.

- To appeal by phone: Contact **Los Angeles County DMH Treatment Authorization Request Unit** between **8:00 am to 5:00 pm** by calling **(213)739-7300**. Or, if you have trouble hearing or speaking, please call **(213)738-4888**.
- To appeal in writing: Fill out an appeal form or write a letter to your plan and send it to:

**Los Angeles County Department of Mental Health TAR Unit
550 South Vermont Avenue 7th Floor Los Angeles CA 90020**

Your provider will have appeal forms available. **Los Angeles County DMH Treatment Authorization Request Unit** can also send a form to you.

You may file an appeal yourself. Or, you can have someone like a relative, friend, advocate, provider, or attorney file the appeal for you. This person is called an “authorized representative.” You can send in any type of information you want your Plan to review. Your appeal will be reviewed by a different provider than the person who made the first decision.

Your Plan has 30 days to give you an answer. At that time, you will get a “Notice of Appeal Resolution” letter. This letter will tell you what the Plan has decided. **If you do not get a letter with the Plan’s decision within 30 days, you can ask for a “State Hearing” and a judge will review your case.** Please read the section below for instructions on how to ask for a State Hearing.

EXPEDITED APPEALS

If you think waiting 30 days will hurt your health, you might be able to get an answer within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an “**expedited appeal.**”

STATE HEARING

If you filed an appeal and received a “Notice of Appeal Resolution” letter telling you that your Plan will still not provide the services, or **you never received a letter telling you of the decision and it has been past 30 days**, you can ask for a “State Hearing” and a judge will review your case. You will not have to pay for a State Hearing.

You must ask for a State Hearing within **120 days** from the date of the “Notice of Appeal Resolution” letter. You can ask for a State Hearing by phone, electronically, or in writing:

- **By phone:** Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.
- **Electronically:** You may request a State Hearing online. Please visit the California Department of Social Services’ website to complete the electronic form: <https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx>
- **In writing:** Fill out a State Hearing form or send a letter to:

**California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430**

Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. You may want to ask your provider or Plan to write a letter for you, or you can write one yourself. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an “**expedited hearing**” and provide the letter with your request for a hearing.

Authorized Representative

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, provider, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an “authorized representative.”

LEGAL HELP

You may be able to get free legal help. You may also call the local Legal Aid program in your county at **1-888-804-3536**.

NONDISCRIMINATION NOTICE

Discrimination is against the law. ***Los Angeles County Department of Mental Health*** follows Federal civil rights laws. ***Los Angeles County Department of Mental Health*** does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

Los Angeles County Department of Mental Health provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact ***DMH ACCESS Center*** 24 hours a day, 7 days a week by calling ***(800) 854-7771***. Or, if you cannot hear or speak well, please call ***(800) 854-7771***.

HOW TO FILE A GRIEVANCE

If you believe that **Los Angeles County Department of Mental Health** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with **Los Angeles County Department of Mental Health**. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact **Patient's Rights** between **8:00 am to 5:00 pm** by calling **(213)738-4888**. Or, if you cannot hear or speak well, please call **(800)854-7771**.
- In writing: Fill out a grievance form, or write a letter and send it to:

**Los Angeles County Department of Mental Health, Patient's Rights Office
550 South Vermont Avenue, Los Angeles, CA 90020**

In person: Visit **Los Angeles County Department of Mental Health, Patient's Rights Office 550 South Vermont Avenue, Los Angeles, CA 90020** and say you want to file a grievance.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

**U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201**

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- Electronically: Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

LANGUAGE ASSISTANCE

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (800) 854-7771 (TTY: (213) 738-4888).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call (800) 854-7771 (TTY: (800) 854-7771).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 854-7771 (TTY: (800) 854-7771).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 854-7771 (TTY: (800) 854-7771).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 854-7771 (TTY: (800) 854-7771).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

(800) 854-7771 (TTY: (800) 854-7771) 번으로 전화해 주십시오.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 854-7771

(TTY: (800) 854-7771)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք (800) 854-7771 (TTY (հեռատիպ)՝ (800) 854-7771):

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 854-7771 (телетайп: (800) 854-7771).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با ((800) 854-7771 (TTY: (800) 854-7771) تماس بگیرید.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

(800) 854-7771 (TTY: (800) 854-7771) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 854-7771 (TTY: (800) 854-7771).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

(800) 854-7771 (TTY: (800) 854-7771) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 854-7771

(رقم هاتف الصم والبكم: (800) 854-7771).

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

(800) 854-7771 (TTY: (800) 854-7771) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 854-7771 (TTY: (800) 854-7771).

