**County of Fresno**

DEPARTMENT OF BEHAVIORAL HEALTH

SUSAN L. HOLT

DIRECTOR OF BEHAVIORAL HEALTH

PUBLIC GUARDIAN

**NOTICE OF ADVERSE BENEFIT DETERMINATION**

**About Your Financial Liability**

September 22, 2021

Name of Person Served Treating Provider’s Name

Address Address

City, State Zip City, State Zip

RE: Service requested

Fresno County Mental Health s has denied your dispute of financial liability regarding insert a description of the disputed financial liability (e.g., cost-sharing, co-insurance, other liabilities). This is because Using plain language, insert a clear and concise explanation of the reasons for the denial. If further information is need, indicate what further information is needed and/or additional steps need be taken, if necessary

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 FCMHP at 1-800-654-3937.

The FCMHP can help you with any questions you have about this notice. For help, you may call the FCMHP 24 hours a day, 7 days a week at 1-800-654-3937 24 hours a day, 7 days a week. If you have trouble speaking or hearing, please call TTY/TTD 711 to reach the California Relay Service, which is available 24 hours a day, 7 days a week for help.

If you need this notice and/or other documents from the FCMHP 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 FCMHP by calling 1-800-354-3937.

If the FCMHP 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, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

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

Name of "Decision-Maker"

Title of "Decision-Maker"

Direct Line of "Decision-Maker"

Enclosures: NOABD “Your Rights”

Language Assistance Taglines

Beneficiary Non-Discrimination Notice

CC:

YOUR RIGHTS UNDER MEDI-CAL

If you need this notice and/or other documents from the Fresno County Mental Health Plan (FCMHP) 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 FCMHP by calling 1-800-654-3937.

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

**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 FCMHP 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 FCMHP will provide you with free assistance if you need help.

* To appeal by phone: Contact FCMHP 24 hours a day, 7 days a week by calling 1-800-654-3937. Or, if you have trouble hearing or speaking, please call TYY/TDD number 711 to reach the California Relay Service.
* To appeal in writing: Fill out an appeal form or write a letter to FCMHP and send it to:

Fresno County Mental Health Plan

P.O. Box 45003

Fresno, CA 93718-9886

Your provider will have appeal forms available. FCMHP 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 FCMHP to review. Your appeal will be reviewed by a different provider than the person who made the first decision.

The FCMHP 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 FCMHP has decided. **If you do not get a letter with the FCMHP’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 the FCMHP 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.

**Temporary Changes to State Fair Hearing Request Timeframes**

If the 120-days deadline occurs between March 1, 2020, through the end of the COVID-19 public health emergency, you are now allowed up to an additional 120 days to request a State Hearing (i.e. initial 120 day timeframe plus an additional 120 days, for a total of 240 days).

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 FCMHP 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. The Fresno County Mental Health Plan (FCMHP) follows Federal and State civil rights laws. The FCMHP does not discriminate, exclude people, or treat them differently.

The FCMHP 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 the FCMHP 24 hours a day, 7 days a week by calling 1-800-654-3937. Or, if you cannot hear or speak well, please dial 711 to reach the California Relay Service, which is available 24 hours a day, 7 days a week.

**HOW TO FILE A GRIEVANCE**

If you believe that the FCMHP has failed to provide these services or discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by Federal or State civil rights laws, you can file a discrimination grievance with the California Department of Health Care Services – Office of Civil Rights. You can file a grievance by phone, in writing, or email:

* By phone: Call **1-916-440-7370**. If you cannot speak or hear well, please call **TTY/TDD 711.**
* In writing: Fill out a grievance form, or write a letter and send it to:

**Office of Civil Rights**

**Department of Health Care Services**

**PO Box 997413, MS 0009,**

**Sacramento, CA 95899-7413**

Complaint forms are available at <https://www.dhcs.ca.gov/discrimination-grievance-procedures>.

* Email: **CivilRights@dhcs.ca.gov**.

**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: Visitthe Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.



**Fresno County Mental Health Plan**

**Language Assistance Taglines**

**English Tagline**

ATTENTION: If you need help in your language call [1-800-654-3937] (TTY: [711]). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call [1-800-654-3937] (TTY: [711]). These services are free of charge.

**الشعار بالعربية (Arabic)**

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ [1-800-654-3937]   
(TTY: [711]). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ [1-800-654-3937]   
(TTY: [711]). هذه الخدمات مجانية.

**Հայերեն պիտակ (Armenian)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք [1-800-654-3937] (TTY: [711])։ Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ` Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր։ Զանգահարեք [1-800-654-3937] (TTY: [711] Այդ ծառայություններն անվճար են։

**ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)**

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ [1-800-654-3937] (TTY: [711])។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ [1-800-654-3937] (TTY: [711])។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

**简体中文标语 (Chinese)**

请注意：如果您需要以您的母语提供帮助，请致电 [1-800-654-3937]   
(TTY: [711])。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 [1-800-654-3937] (TTY: [711]) 。这些服务都是免费的。

**(Farsi) مطلب به زبان فارسی**

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با [1-800-654-3937] (TTY: [1-800-654-3937]) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با [1-800-654-3937] (TTY: [711]) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

**हिंदी टैगलाइन (Hindi)**

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो [1-800-654-3937]   
(TTY: [711]) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। [1-800-654-3937] (TTY: [711]) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

**Nqe Lus Hmoob Cob (Hmong)**

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau [1-800-654-3937] (TTY: [711]). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau [1-800-654-3937] (TTY: [711]). Cov kev pab cuam no yog pab dawb xwb.

**日本語表記 (Japanese)**

注意日本語での対応が必要な場合は [1-800-654-3937] (TTY: [711])へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 [1-800-654-3937] (TTY: [711]) へお電話ください。これらのサービスは無料で提供しています。

**한국어 태그라인 (Korean)**

유의사항: 귀하의 언어로 도움을 받고 싶으시면 [1-800-654-3937] (TTY: [711]) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. [1-800-654-3937] (TTY: [711]) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

**ແທກໄລພາສາລາວ (Laotian)**

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ [1-800-654-3937] (TTY: [711]). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສຳລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ   
[1-800-654-3937] (TTY: [711]). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

**Mien Tagline (Mien)**

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux [1-800-654-3937]   
(TTY: [711]). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx [1-800-654-3937] (TTY: [711]). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

**ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)**

**ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ [1-800-654-3937]  
(TTY: [711]). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ [1-800-654-3937] (TTY: [711]).  
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

**Русский слоган (Russian)**

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру [1-800-654-3937] (линия TTY: [711]). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру [1-800-654-3937] (линия TTY:  
[711]). Такие услуги предоставляются бесплатно.

**Mensaje en español (Spanish)**

ATENCIÓN: si necesita ayuda en su idioma, llame al [1-800-654-3937]   
(TTY: [711]). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al   
[1-800-654-3937] (TTY: [711]). Estos servicios son gratuitos.

**Tagalog Tagline (Tagalog)**

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa   
[1-800-654-3937] (TTY: [711]). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa [1-800-654-3937] (TTY: [711]). Libre ang mga serbisyong ito.

**แท็กไลน์ภาษาไทย (Thai)**

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข   
[1-800-654-3937] (TTY: [711]) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข [1-800-654-3937] (TTY: [711]) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

**Примітка українською (Ukrainian)**

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер [1-800-654-3937] (TTY: [711]). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер [1-800-654-3937] (TTY: [711]). Ці послуги безкоштовні.

**Khẩu hiệu tiếng Việt (Vietnamese)**

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số   
[1-800-654-3937 (TTY: [711]). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số [1-800-654-3937] (TTY: [711]). Các dịch vụ này đều miễn phí.