**County of Fresno**

DEPARTMENT OF BEHAVIORAL HEALTH

SUSAN L. HOLT

DIRECTOR OF BEHAVIORAL HEALTH

PUBLIC GUARDIAN

**NOTICE OF ADVERSE BENEFIT DETERMINATION**

**About Your Treatment Request**

September 22, 2021

Name of Person Served Treating Provider’s Name

Address Address

City, State Zip City, State Zip

Phone Number

RE: Specialty Mental Health Services

You are currently interested in or receiving specialty mental health services through the Fresno County Mental Health Plan (FCMHP). Beginning on August 9, 2021 we will no longer approve this treatment. This is because we have not been able to reach you. We would like a chance to be able to meet with you to discuss your request for services. Please contact Treating Provider’s Name at Phone Number if you would like service(s). If we do not hear from you, we will assume you agree with the decision, you are no longer in need of our services, or you have accessed services with another provider.

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 weused to makeour decision. To ask for this, please call Fresno County Mental Health Plan (FCMHP)at 1-800-654-3937.

If you want to keep getting this service 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 plan says services will be stopped or reduced, listed above.

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

The FCMHP can help you with any questions you have about this notice. For help, you may call FCMHP 24 hours a day, 7 days a weekat 1-800-654-3937.If you have trouble speaking or hearing, please call TTY/TTD number 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 FCMHPby calling 1-800-654-3937.

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.

Treating Provider’s Name

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**

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-654-3937 (TTY: 711). **(English)**

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 1-800-654-3937 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-654-3937 (TTY: 711). **(Spanish)**

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-654-3937 (TTY: 711). **(Hmong)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغویة تتوافر لك بالمجان. اتصل برقم 1-800-654-3937 (711- ھاتف الصم والبكم) **(Arabic)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-654-3937 (TTY (հեռատիպ)՝ 711): **(Armenian)**

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-654-3937 (TTY: 711)។ **(Cambodian/Khmer)**

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 1-800-654-3937

(TTY：711）。**(Chinese)**

**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-654-3937 (TTY: 711) تماس بگیرید. **(Farsi)**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-654-3937 (TTY: 711) पर कॉल करें। **(Hindi)**

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。1-800-654-3937（TTY:711）まで、お電話にてご連絡ください。**(Japanese)**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-654-3937 (TTY: 711)번으로 전화해 주십시오. **(Korean)**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-654-3937 (TTY: 711). **(Lao)**

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-654-3937 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। **(Punjabi)**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-654-3937 (телетайп: 711). **(Russian)**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-654-3937 (TTY: 711). **(Tagalog)**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-654-3937 (TTY: 711). **(Thai)**

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-654-3937(телетайп: 711). **(Ukranian)**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-654-3937 (TTY: 711). **(Vietnamese)**