PM FORM 5.2.1

ADHS/DBHS APPEAL OR SMI GRIEVANCE FORM

Client/Applicant Information:

Name: _____
(Last, First, M.I.)

Address: _____
Street City State Zip Code

Phone: (_____)_____ Date of Birth: _____

Information about the person filing (if different than above):

Name: _____
(Last, First, M.I.)

Address: _____
Street City State Zip Code

Phone: (_____)_____

Relationship to the Client/Applicant (i.e. Provider, Parent or Guardian): _____

Description of Appeal or Grievance: [Please include dates, names, locations, also any other attempts to resolve the problem, attaching additional pages as necessary.]

_____
_____
_____

What solution do you want?_____
_____
_____

<u>Continuation of Services</u>:

For clients with a serious mental illness, your services under appeal will be continued during the appeal process, unless doing so poses a serious threat of harm to you or others.

For appeals relating to Title XIX or XXI services, please check *one* of the following:

- ❑ I am requesting that the services I am appealing be continued during the appeal process. I understand that if I lose my appeal, I may be required to pay for the cost of the services that were continued during the appeal process.
- ❑ I do not want the services I am appealing to be continued during the appeal process.

Client Signature: _____ Date: _____