

**PM FORM 5.3.1
ADHS/DBHS APPEAL OR SMI GRIEVANCE FORM**

Member/Applicant Information:

Name (Last, First, M.I.)		Date	
Address	City	State	Zip code
Phone	Date of Birth		

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

Name (Last, First, M.I.)			
Address	City	State	Zip code
Phone			

Relationship to the Member/Applicant (i.e. Provider, Parent or Guardian)	
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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?	

Continuation of Services:
For members 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:
Provider, Parent or Guardian Signature	Date: