



**NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request**

[Date]

[Beneficiary's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Treating Provider's Address]
[City, State Zip]

RE: *[Service requested]*

[Name of requestor] has asked Sonoma County Behavioral Health Mental Health Plan (the MHP) to approve *[Service requested]*. This request is denied. The reason for the denial is *[Using plain language, insert a clear and concise explanation of the reason(s) for the decision and the clinical reason(s) for the decision regarding medical necessity]*.

Per the Code of Federal Regulations, Title 42, Section 438.400(b)(3), the MHP may deny in whole, or in part, a beneficiary's request for service(s), when **(all items selected below apply)**:

- A) The beneficiary does not meet medical necessity criteria for Specialty Mental Health Services (Title 9, Ch.11, Sections 1830.205/1830.210), psychiatric inpatient hospital services, or related professional services (Section 1820.205)
- B) The requested service(s) is excluded from reimbursement (Sections 1810.355/1840.312)
- C) The person for which the service(s) is being requested is ineligible for said service(s) (42 CFR 435.403)
- D) The MHP requested additional information from your provider that the MHP needs to approve payment of the proposed service(s). To date, the information has not been received (Title 9, Ch.11, Section 1840.314)
- E) The provider did not agree to/satisfy the MHP contractual agreements, or Medi-Cal reporting/documentation requirements (Sections 1840.314/1840.316)

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 Sonoma County Behavioral Health (SCBH) Access Team (24/7) at 1-800-870-8786 (toll-free) or 707-565-6900.

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 The 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 SCBH Access Team (24/7) at 1-800-870-8786 (toll-free) or 707-565-6900. If you have trouble speaking or hearing, please call TTY number 1-800-735-2929 or 711 for help.

If you need this notice and/or other documents from the MHP 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 MHP by calling 707-565-6900 or 1-800-870-8786 (24/7).

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

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

[Signature Block]

Enclosures:

“Your Rights”

“Language Assistance Taglines”

“Beneficiary Non-Discrimination Notice”



YOUR RIGHTS UNDER MEDI-CAL

If you need this notice and/or other documents from the MHP 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 MHP by calling 707-565-6900 or 1-800-870-8786 (24/7).

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 Sonoma County Behavioral Health Grievance Coordinator by calling 707-565-7895 (Mon-Fri 8am-5pm) or calling 1-800-870-8786 (toll-free) 24/7. Or, if you have trouble hearing or speaking, please call 1-800-735-2929 or 711.
- **To appeal in writing:** Fill out an appeal form or write a letter to your plan and send it to:

***Sonoma County Behavioral Health
C/O Grievance Coordinator
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407-5419***

Your provider will have appeal forms available. The MHP 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.

LANGUAGE ASSISTANCE

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 24/7 toll-free 1-800-870-8786 toll free number or 707-565-6900 (TTY: 1-800-735-2929 or 711).

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 707-565-6900 or 1-800-870-8786 (TTY: 1-800-735-2929 or 711).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711).

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 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711) 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 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆՆԵՐ ԵՐԵ խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (1-800-735-2929 or 711) TTY: 1-800-870-8786 or 707-565-6900 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。1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711) 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 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-870-8786

or 707-565-6900 (رقم هاتف الصم والبكم: 1-800-735-2929 or 711)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। [1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711).

ខ្មែរ(Cambodian)

ប្រយ័ត្ន: រ រ សើ ិនជាអ្នកនិយាយ ភាសាខ្មែរ , រសវាជំនួយមននកភាសា រោយមិនគិត ្នន គឺអាចមានសំរ ំរ រ រ ើ នក។ ចូ ូ សំរ ្ន1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711)។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-870-8786 or 707-565-6900 (TTY: 1-800-735-2929 or 711).

NONDISCRIMINATION NOTICE

Discrimination is against the law. The MHP follows Federal civil rights laws. The MHP does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

The MHP 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 SCBH Access Team (24/7) by calling 1-800-870-8786 (toll-free) or 707-565-6900. Or, if you cannot hear or speak well, please call 1-800-735-2929 or 711.

HOW TO FILE A GRIEVANCE

If you believe that the MHP 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 the MHP. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact Sonoma County Behavioral Health Grievance Coordinator by calling 707-565-7895 (Mon-Fri 8am-5pm) or calling 1-800-870-8786 (toll-free) 24/7. Or, if you have trouble hearing or speaking, please call 1-800-735-2929 or 711.
- **In writing:** Fill out a grievance form, or write a letter and send it to:

**Sonoma County Behavioral Health
C/O Grievance Coordinator
2227 Capricorn Way, Suite 207
Santa Rosa, CA 95407-5419**

- **In person:** Visit your provider's office or the MHP 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>.