



**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]*

[You or your provider (Name of requesting provider)] has asked *[Sonoma County Behavioral Health Mental Health Plan (the MHP)] provider* to obtain or approve *[Service requested]*. Our records show that you requested service(s), or service(s) were requested on your behalf on *[date requested]*. The MHP has not yet made a decision about the request.

We apologize for the delay in processing this request. We are working on your request and will provide *[you or your provider (Name of requesting provider)]* with a decision as soon as possible.

You may appeal this decision. 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.

The Plan can help you with any questions you have about this notice. For help, you may call the Sonoma County Behavioral Health (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 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]

Enclosed: "Your Rights"
Language Assistance Taglines



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

