

PM FORM 5.3.1

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? _____

Continuation of Services:

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: _____