



**NOTICE OF ACTION
About Your Mental Health Treatment Request
Terminate/Suspend/Reduce**

[Date]

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

[Treating Provider's Name]
[Address]
[City, State Zip]
[Name of Provider/Clinic/CAU]

HWLA Member Identification Number: *[insert number]*
DMH IS Number: *[insert number]*

RE: *[insert type of service terminated, suspended or reduced]*

We have previously approved *(insert type of service that was approved)*.
However, we can no longer approve this treatment because *(Insert a clear and concise explanation of the reasons for the decision; the program requirements that support the action; a description of the criteria or guidelines used)*.

Approval for your treatment will end on *(insert advance date to be at least 12 calendar days from date of letter)*

NOTE: If you cannot read or understand this letter, call the Department of Mental Health Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

As a DMH Healthy Way LA (HWLA) member, you have the following appeal rights:

1. You have the right to appeal this decision. That means that if you do not agree, you can have us review the decision. If you want to appeal this decision, you must ask for the appeal within **60 days** of the date of this Notice of Action letter. It can take up to 45 days for DMH Patients' Rights Office to decide your appeal.

If you think that waiting this long could put your life or health at serious risk, or put at serious risk your ability to get back the most function possible, ask for an expedited appeal. DMH Patients' Rights will decide an expedited appeal within 3 working days.

If you want to continue this treatment while waiting for a decision on your appeal, you must ask for the appeal within **10 days** from the date of this letter.

Your services will continue if:

- 1) **You ask for your appeal within 10 days of the date of this letter;**
- 2) The services were ordered by a mental health provider.
- 3) The original period of approved services has not ended; and
- 4) You ask to continue the treatment while the appeal is going on.

If you lose the appeal you may have to pay for the cost of the services that you received while the appeal was going on.

To ask for a regular or expedited appeal, call DMH Patients' Rights at (213) 738-4949. If you have problems hearing or speaking, call TTY/TDD at (800) 735-2929. We will help you with your appeal. You can also request for your appeal by writing or sending a fax to:

**DMH Patients' Rights
550 S. Vermont Ave.
Los Angeles, CA 90020
Fax: (213) 365-2481**

2. You have the right to speak for yourself during the appeal or choose another person to act for you. That person may be a relative, friend, advocate, doctor, lawyer or someone else.
3. You may send written comments, documents, records and other information about your appeal. You may also ask that a hearing be held in person or by telephone where you can give the reasons why you disagree and examine and cross-examine witnesses.
4. Except in some limited cases you will be able to review your case file before and during the appeal process.
5. If, after we make our decision, you are still not satisfied, you may ask for a State Fair Hearing. You may ask for a State Fair Hearing only **after** you have finished the HWLA appeal process and have received a decision letter.

If you have questions, concerns, want to give information about your appeal, or want to ask for a hearing in person or on the telephone with the person deciding your appeal, call the DMH Patients' Rights at (213) 738-4949, or use TTY/TDD at (800) 735-2929.

This notice does not affect any other HWLA services.

Sincerely,

(Name of Provider of Services or CAU Reviewer)

c: DMH Patients' Rights
Requesting Provider