COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

FULL SERVICE PARTNERSHIP APPEAL FORM

DATE: _____ ☐ **Child** ☐ **TAY** ☐ **Adult** ☐ **Older Adult**

Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

CLIENT LAST NAME: _____ **CLIENT FIRST NAME:** _____ **DOB:** _____ **SSN:** _____ **DMH IS#:** _____

Reason for Appeal (Check ONE Only):

☐ DMH Impact Unit has referred an eligible client to our agency that we decline to enroll.

☐ Our agency has requested authorization to enroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to enroll.

☐ Our agency has requested authorization to disenroll a client and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to disenroll.

☐ Our agency has requested authorization to transfer a client between FSP programs and DMH Impact Unit or DMH Countywide Programs Administration has denied permission to transfer.

Explain Reason for Appeal:

Fax completed Appeal Form and copy of denied request to appropriate **Service Area District Chief.**

↓↓TO BE COMPLETED BY SERVICE AREA DISTRICT CHIEF↓↓

District Chief Name: _____ Service Area: _____

Phone: ( ) _____ Fax: ( ) _____

DISPOSITION: ☐ APPEAL APPROVED ☐ APPEAL DENIED

Explain Reason for Decision: _____

Service Area District Chief Signature: _____ Date _____

Countywide District Chief Signature: _____ Date _____