



Behavioral Health

NOTICE OF ACTION
(ASSESSMENT: NOA-A)

Date: _____

To: _____, Medi-Cal Number: _____

The San Bernardino County Department of Behavioral Health has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the Department of Behavioral Health's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

- Four checkbox options for reasons: 1) diagnosis not covered, 2) condition not serious enough, 3) services not helpful, 4) responsive to physical care provider.

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of the San Bernardino County Department of Behavioral Health at (888) 743-1478 or write to: Access Unit, 303 E. Vanderbilt Way, 3rd Floor, San Bernardino, CA 92415-0026.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of The San Bernardino County Department of Behavioral Health at (888) 743-1478 or write to: Access Unit, 303 E. Vanderbilt Way, 3rd Floor, San Bernardino, CA 92415-0026.

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of the San Bernardino County Department of Behavioral Health at (888) 743-1478 or write to: Access Unit, 303 E. Vanderbilt Way, 3rd Floor, San Bernardino, CA 92415-0026 or follow the directions in the information brochure the mental health plan has given you.

If you have questions about this notice, you may call and talk to a representative of the San Bernardino County Department of Behavioral Health at (888) 743-1478 or write to: Access Unit, 303 E. Vanderbilt Way, 3rd Floor, San Bernardino, CA 92415-0026.

If you are dissatisfied with the outcome of your appeal, you may request a state hearing. The other side of this form will explain how to request a hearing.

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

- 1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
- 2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait For A Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:
Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.). The information you are asked to write on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2).

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

Another way to request a hearing is online at <http://www.dss.cahwnet.gov/shd/PG1110.htm>.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the San Bernardino County Department of Behavioral Health.

- Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

- Check here and add a page if you need more space.

My name: (print) _____

My Social Security Number: _____

My Address: (print) _____

My phone number: (____) _____

My signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name _____

Address _____

Phone number: _____