

County of Santa Barbara
Mental Health Plan
Appeal

Please complete the top half of this form with the information requested and mail it to:

ADMHS Beneficiary Concerns
315 Camino del Remedio #257
Santa Barbara, CA 93110

Appeal Options:

- Standard Appeal:** 45 days for resolution (Standard appeal requires that an action has been taken by Mental Health Program. For example, services have been terminated, reduced, or a change in level of care previously granted has been altered. Title 9, Section 1850.205)
- Expedited Appeal:** 3 days for resolution (Expedited appeal requires that an action has been taken by Mental Health Program & when using standard process could jeopardize the beneficiary's life, health, or ability to attain maintain, or regain maximum function. Title 9, Section 1850.205)

Date: _____

To: Beneficiary Concerns Representative

I wish to submit an appeal about: _____

for the following reasons: _____

I am willing to offer additional information by phone or in person.

My Phone: _____
Telephone Number

My Address: _____
Address

_____ **City** **Zip Code**

PRINT NAME: _____ **SIGNATURE:** _____

DATE OF BIRTH: _____

THE SECTION BELOW TO BE COMPLETED BY ADMHS BENEFICIARY CONCERNS

Client's Name: _____ Date received: _____

Oral appeal received by _____ Appeal was reviewed on _____ by _____

Response: _____

Expedited? Yes No Reason: _____

Response was provided in writing on _____

If client is a Medi-Cal beneficiary, information on State Fair Hearing sent along with a response? Yes No