Date : Medicaid #:

Client Telephone Number:

Dear _____:

PermiaCare has reviewed the following:
Your continued participation in MH Rehab Services

PermiaCare has the following:
We have been unable to get in touch with you

This determination was made because: _____

The following rule of the Texas Department of State Health Services authorizes us to make this determination: **(Non-applicable if discharge is at person's request).**

☒ {25 TAC §419.455} Medicaid Mental Health Rehabilitative Services
In order for an individual to be eligible for rehabilitative services for which a Medicaid provider is reimbursed by Medicaid, the individual must meet the criteria below. According to our information, you no longer meet the following criteria:

☒ {25 TAC §412.405} Mental Health Case management Services
To be eligible for MH Case management Services, an individual must meet the criteria below. According to our information, you no longer meet the following criteria:

This means: you will no longer receive these services

If you disagree with this decision, you have the following options:

☒ If your case is being closed because **PermiaCare** has not been able to contact you and/or have not heard from you, you will need to contact your Case Manager, _____ at _____ within 10 days.

and/or

☒ You can contact Susan Halydier, Clients Rights Advocate for PermiaCare, at (432)570-3333 .

and/or

☒ You may request a fair hearing to appeal the decision as provided under the rules of DSHS {25 TAC §419.467 for MH Rehabilitative Services and 25 TAC §412.414 for Case Management}. If you request a fair hearing, you may represent yourself or you may choose an authorized representative, such as a relative, friend, lawyer or other spokesperson, to represent you at your expense. If you wish to appeal, you must request a fair hearing in writing and your request must be received by DADS on or before _____ *(90 days from date of letter).* You will lose your right to appeal this decision if your request is not received by this date.

You may request a fair hearing by completing the enclosed form and mailing it to:

DSHS – Mental Health and Substance Abuse Unit
Consumer Services & Rights Protection Division
P.O. Box 149347
MC 2018
Austin, Texas 78714-9347

If we do not hear from you by _____ (10 days from the date of this letter) and/or we do not receive notice from TDSHS that you have filed an appeal, we will assume that you accept our decision. **REMEMBER:** Even if you are not receiving services from our Center, you can always access crisis services by phone at 1-800-542-4005 or by walking into the Mental Health Center M-F, 8-5. The crisis services are available by phone 24 hours a day, 7 days a week. You may also re-apply for services, if the need arises, after the case is closed.

If you have questions about any of the information in this letter, please contact
_____ at _____.

Sincerely,

____

This letter was sent by certified mail, return receipt requested on ________.
or
This letter was hand-delivered as acknowledged by ________________________
(Signature of Consumer or LAR)

Abbreviations that may appear within the body of this letter:

CM=Case Manager or Case Management
DADS=Department of Aging and Disability Services
DSHS=Department of State Health Services
ICF=Intermediate Care Facility
IMD=Institution for Mental Disease
LAR=Legally Authorized Representative
LOC=Level of Care
LPHA=Licensed Practitioner of the Healing Arts
MH=Mental Health
MR=Mental Retardation
PASARR=Pre-Admission Screening And Resident Review assessment
PDD=Pervasive Developmental Disorder
SA=Substance Abuse
TAC=Texas Administrative Code

_______________________________ ________________
Consumer Name *Medicaid Number*

____
Mailing Address

____
City, State Zip

FAIR HEARING REQUEST FORM

(There is no need to complete or send this letter unless you disagree with the decision made by PermiaCare to deny, terminate or reduce services)

PermiaCare made the following determination:

I wish to appeal this determination.

Signature of Consumer / Representative **Date**

Complete the following only if you have the information available at the time you are requesting your fair hearing. You are entitled to representation, at your own expense, at any time during the fair hearing process.

NAME AND ADDRESS OF REPRESENTATIVE:

______________________________________ __________________________
Relationship

____

Return this form to:

DSHS – Mental Health and Substance Abuse Unit
Consumer Services & Rights Protection Division
P.O. Box 149347 MC 2018
Austin, Texas 78714-9347