OFFICE OF SUBSTANCE ABUSE
DIVISION OF MACOMB COUNTY COMMUNITY MENTAL HEALTH SERVICES
22550 Hall Road, Clinton Twp., MI 48036
(586) 469-5278 Fax (586) 469-5568 mcosa@mccmh.net

Dear Consumer:

Your therapist at _____ requested Initial / Additional_____
(Treatment Agency) **(Circle One)**

Substance use services for you. See below for the specific details and time frame. Receiving this letter means that the Macomb County Office of Substance Abuse (MCOSA), or the Macomb County Community Mental Health Access Center, has reviewed and processed the requested treatment services.

If dissatisfied with the authorization and you are a **Medicaid/Healthy Michigan beneficiary**, you may file a **Medicaid/Healthy Michigan Local Appeal** with MCOSA within 45 days of receipt of this letter. A Local Appeal form and/or additional information about the Local Appeal process may be requested from your therapist or from MCOSA at the address and phone number above. If this is an expedited request, you will receive an answer in no more than three (3) days; otherwise you will hear a response within 45 calendar days.

A **Medicaid/Healthy Michigan beneficiary** dissatisfied with this authorization is also entitled to file a request for a State **Fair Hearing** with the Michigan Department of Community Health (MDCH) within 90 days. A Request for Fair Hearing form may be obtained from MCOSA or the treatment program, but it must be sent directly to MDCH. The Fair Hearing form and envelope will be provided to you at no cost. Medicaid/Healthy Michigan beneficiaries will also receive written notice if previously authorized services are reduced or discontinued by MCOSA or the Access Center. Accommodations will be made for you if you have difficulty reading or writing English. If a Fair Hearing request is submitted prior to the effective date of any action, the services will be continued until the hearing is complete. A Local Appeal and State Fair Hearing can occur at the same time.

As a **Medicaid/Healthy Michigan beneficiary,** you may have another person request and/or represent you at a Fair Hearing. This person may be anyone you choose, but you MUST give this person written permission to file a request and/or represent you, except if they are your spouse, lawyer or court-appointed guardian. For more information call toll free: 877-833-0870. If this is an expedited request, you will receive a reply in no more than three (3) days otherwise a hearing may occur within 30 days.

As a **Medicaid/Healthy Michigan beneficiary**, you may also file a Local Grievance if you have a complaint other than an authorization, reauthorization, denial, suspension or discontinuation of your services. You will receive a response within 60 days of filing the Local Grievance. If waiting that long causes serious harm, the grievance will be reviewed and a decision made within 24 hours of its receipt but no later than 3 business days. If MCOSA determines your grievance does not require immediate attention, you will receive prompt notice of this and the response will occur within the 15-60 day time frame. Additional information may be requested from the provider/MCOSA at your request explaining the Local Grievance process.

All recipients of substance use services are also entitled to submit Recipient Rights complaints if you believe your rights have been violated. Medicaid/Healthy Michigan beneficiaries may file a rights complaint instead of or in addition to filing a Local Grievance, a Local Appeal and/or a request for a Medicaid Fair Hearing. For more information about Recipient Rights, contact the program's Rights Advisor or MCOSA.

Number Sessions/Days/Doses Requested:			**Number Sessions/Days/Doses Approved**:		
Assessment	_____		Assessment	_____	
Individual	_____		Individual	_____	
Group	_____		Group	_____	
Didactic	_____		Didactic	_____	
Doses	_____		Doses	_____	
Psych. Eval.	_____	(for Block Grant only)	Psych. Eval	_____	(for Block Grant only)
Med. Review	_____	(for Block Grant only)	Med. Review	_____	(for Block Grant only)
IOP Days	_____		IOP Days	_____	
Detoxification Days	_____		Detoxification Days	_____	
Residential Days	_____		Residential Days	_____	
_____	_____		_____	_____	
_____	_____		_____	_____	

Authorization **Effective Date Requested:** _____ Authorization **Effective Date Approved:** _____
Authorization **Lapse Date Requested:** _____ Authorization **Lapse Date Approved:** _____

I have received a copy of this letter and understand my rights as a consumer of funded substance use services.

_____ _____
Consumer Name **Date**

The legal reason for the above letter and stipulations is 42 CFR 440.230(d) for Medicaid beneficiaries**. Rev. 10/14**