



Notice of Adverse Action – Resolution of Complaints Involving Summit DD Board

Name: _____ Mailing/Delivery Date: _____

Address: _____

City,State, Zip Code: _____

Phone: _____

DoDD #: _____

Non-Medicaid Service: _____

Summit DD Policy #: _____

This notice is to advise you that Summit DD is taking the following adverse action as it relates to the service described above:

- Denial of a request for a non-Medicaid service
- Reduction in frequency and/or duration of a non-Medicaid service
- Suspension of a non-Medicaid service
- Termination of a non-Medicaid service
- An emergency situation that impacts health and safety in which your services are being suspended immediately

The reason for this action is:

This action will take effect on: _____

IF YOU DISAGREE WITH THIS DECISION, YOU HAVE THE RIGHT TO AN INFORMAL AND FORMAL PROCESS FOR RESOLUTION OF COMPLAINTS AND APPEAL OF ADVERSE ACTION:

INFORMAL: PLEASE CONTACT _____ AT _____ TO DISCUSS YOUR COMPLAINT OR APPEAL AND TRY AND RESOLVE THE ISSUE. This process will take no longer that 30 days.

FORMAL: WITHIN 90 CALENDAR DAYS OF BECOMING AWARE OF THE ADVERSE ACTION, YOU MUST FILE YOUR COMPLAINT OR APPEAL. IF YOU DO NOT FILE WITHIN 90 CALENDAR DAYS, YOU WILL NOT BE ABLE TO KEEP YOUR CURRENT SERVICES IN PLACE DURING THE APPEAL.

YOU MAY FILE YOUR APPEAL IN WRITING WITH _____ AT _____.

During this time your services will not be terminated, reduced, or suspended.

WITHIN 15 CALENDAR DAYS OF THE APPEAL, SUMMIT DD WILL MEET WITH YOU TO DISCUSS THEIR WRITTEN REPORT AND DECISION AND NEXT STEPS IF YOU ARE STILL NOT SATISFIED.

IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE COMPLETING THIS FORM, PLEASE CONTACT _____.

ATTACHMENT: "COMPLAINT OR APPEAL OF ADVERSE ACTION EXPLANATION FORM"