

DEPARTMENTAL MEMORANDUM
MAD-MR: 17-10
DATE: 4/18/2017

**TO: MEDICAL ASSISTANCE DIVISION STAFF AND PROVIDERS OF THE
BRAIN INJURY SERVICES FUND**

FROM: NSL NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION

**THROUGH: SHARI ROANHORSE AGUILAR, BUREAU CHIEF, EXEMPT SERVICES
AND PROGRAMS BUREAU**

BY: LINDA GILLET, BRAIN INJURY PROGRAM/ESPB

SUBJECT: MAD 624 Issued 4-18-2017, BISF Appeals Form

GENERAL INFORMATION

This form is for use by the Contracted Agencies of the Brain Injury Services Fund (BISF) for the purpose of distributing to BISF Program Participants, who wish to file an Appeal with HSD regarding any unresolved grievances with the Contracted Agency.

FILING INSTRUCTIONS

Please make the following changes to the MAD forms manuals:

INSERT MAD 624 Issued 4-18-2017

Please address any questions concerning these guidelines to Lindab.gillet@state.nm.us or call (505) 827-7218.

Attachment: MAD 624 Issued 4-18-2017, BISF Appeals Form



**BRAIN INJURY SERVICES FUND (BISF) PROGRAM
APPEALS FORM**

As a BISF Program participant, you may have unresolved grievances related to services that you are receiving. If the Provider's final decision regarding the formal grievance has not resulted in a mutually agreeable outcome, you have the right to file a written appeal with the HSD BISF Program Manager. Please complete this form and follow the instructions for submitting your appeal within thirty (30) calendar days of the Provider's written response. A written response will be mailed to you within thirty (30) calendar days of HSD's receipt of your appeal. Additional instructions to complete this form can be found on the next page.

DATE: _____

1. BISF PARTICIPANT INFORMATION: Participant Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Email: _____	
2. STATE WHAT DECISION YOU ARE APPEALING.	
3. STATE WHY YOU ARE APPEALING THE DECISION. Include your justification for the appeal, supporting facts, and attach appropriate documentation if applicable. Use additional pages if needed.	
4. PLEASE SIGN AND DATE: _____ Participant Signature _____ Signature of Person Assisting with Appeal _____ Date _____ Date	5. RETURN COMPLETED FORM TO: Linda Gillet, Ph.D Brain Injury Program Manager HDS/MAD/ESPB 2025 S. Pacheco PO Box 2348 Santa Fe, NM 87504
6. FOR OFFICIAL USE ONLY: BISF PROGRAM DETERMINATION/RESOLUTION: _____ _____ Program Manager Signature: _____ Date: _____ Date received: _____	



BRAIN INJURY SERVICES FUND (BISF) PROGRAM APPEALS FORM

FORM INSTRUCTIONS

PURPOSE:

This form is to be completed by a Brain Injury Services Fund (BISF) Program participant, who has concerns or grievances about services delivered by a contracted BISF Provider, which continue to be unresolved after the completion of the Provider's formal grievance process. These services may concern Service Coordination, Life Skills Coaching, or Crisis Interim Fiscal Intermediary Services. A formal participant Appeal should be filed with the New Mexico Human Services Department's Brain Injury Program no later than thirty (30) calendar days, following the date of the Provider's decision letter.

INSTRUCTIONS FOR THE PERSON FILING THE APPEAL:

Please complete boxes 1-4, and mail your appeal to the address noted in Box 5.

Box 6 will be completed by the BISF Program Manager receiving the form.

Box 1: Fill out all applicable information: name, date of birth, complete address, phone and email.

Box 2: Provide a detailed description of what decision from the formal grievance process you are appealing.

Box 3: Provide a brief description of why you are appealing the decision. Include your justification for the appeal, supporting facts, attach appropriate documentation. Use additional pages if needed.

Box 4: Sign and date.

If you need help in completing the form or in expressing your concerns, you may ask your Service Coordinator to provide contact information for a local advocacy agency; or you may contact the NM Brain Injury Resource Center at 1-844-3NM-BIRC (1-844-366-2472) for any help they may offer.

ROUTING:

The signed and completed form is to be sent to:

Linda Gillet, Ph.D

Brain Injury Program Manager

HDS/MAD/ESB

2025 S. Pacheco

PO Box 2348

Santa Fe, NM 87504

FORM RETENTION:

Permanent