HUMAN SERVICES
DEPARTMENT

Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary Designate
Nicole Comeaux, J.D., M.P.H, Director

DEPARTMENTAL MEMORANDUM
MAD-MR: 19-10
DATE: November 14, 2019

TO: **MEDICAL ASSISTANCE DIVISION**

FROM: **NICOLE COMEAUX, DIRECTOR, MEDICAL ASSISTANCE DIVISION**

THROUGH: **SHARI ROANHORSE-AGUILAR, BUREAU CHIEF, EXEMPT SERVICES AND PROGRAMS BUREAU (ESPB)**

BY: **LINDA GILLET, BRAIN INJURY PROGRAM / ESPB**

SUBJECT: **MAD 624 REVISED JUNE 2019, BRAIN INJURY SERVICES FUND (BISF) APPEALS FORM**

GENERAL INFORMATION

The MAD 624 is for use by the Contracted Agencies of the Brain Injury Services Fund (BISF) Program 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. Changes to the form and instructions include the following:

- Form and Instructions: Change of HSD Mailing Address
- Form: Addition of line specifying the BISF Contracted Service Coordination Agency with which the participant is enrolled.
- Form: Addition of checkboxes for "Appeal Concerns: Service Coordination Agency; BISF Home and Community Based Services (HCBS), and NM Brain injury Resource Center (NMBIRC)."
- Instructions: Removal of "Life Skills Coaching"
- Instructions: Replacement of "Crisis Interim Services" with BISF Home and Community Based Services (HCBS).
- Instructions: Removal of NMBIRC telephone number for ARCA and direction to find the NMBIRC telephone number on the HSD website.

FILING INSTRUCTIONS

Please make the following replacements in the Medical Assistance Forms Manual:

DELETE MAD 624 Issued 4-17-2017
INSERT MAD 624 Revised June 2019

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

Attachment: MAD 624 Revised June 2019

HUMAN SERVICES DEPARTMENT

BRAIN INJURY SERVICES FUND (BISF) PROGRAM
APPEALS FORM

You may use this form if you have complaints or "grievances" about your BISF Service Coordination or BISF Home and Community Based Services. The first step is to reach out to your Service Coordination Agency (SCA). They will work to resolve your complaint. If you do not like the final decision of the SCA or other BISF Agency or Service Provider that dealt with your complaint, you can file a written appeal with the HSD BISF Program Manager. To do so, please fill in this form. Send it to the address in Box 6. HSD will contact you to learn more. They will contact the agency or Service Provider too. HSD will also send you a written decision on your appeal. This will come no more than thirty (30) calendar days after they get your appeal form. More help with this form can be found on the next page.

1. BISF PARTICIPANT/PATRON INFORMATION: **DATE:** _____

Participant / Patron Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Name of your BISF Service Coordination Agency: _____

2. THIS APPEAL CONCERNS A DECISION THAT I DID NOT LIKE. THE DECISION WAS: (Check one)

- ☐ Made by the BISF Service Coordination Agency.
- ☐ Related to BISF Home and Community Based Services. If so, which service?_____
- ☐ Made by the NM Brain Injury Resource Center (NMBIRC).

3. STATE WHAT DECISION YOU ARE APPEALING.

4. STATE WHY YOU ARE APPEALING THE DECISION. Give your reasons for the appeal. Add any supporting facts. Attach related documents if you have them. Use more pages, if you need them.

5. PLEASE SIGN AND DATE:

_____ _____

Participant Signature Date

_____ _____

Signature of Person Assisting with Appeal Date

6. RETURN COMPLETED FORM TO:

Linda Gillet, Ph.D
Brain Injury Program Manager
HSD/MAD/ESPB
PO Box 2348
Santa Fe, NM 87504
Or send by email to: LindaB.Gillet@state.nm.us

7. FOR OFFICIAL USE ONLY: Date received: _____

BISF PROGRAM DETERMINATION/RESOLUTION:

_____

_____

Program Manager Signature: _____ Date: _____

HUMAN SERVICES DEPARTMENT

BRAIN INJURY SERVICES FUND (BISF) PROGRAM APPEALS FORM

FORM INSTRUCTIONS

PURPOSE:

The MAD 624 form is to be used by Brain Injury Services Fund (BISF) Program participants to file an appeal. This form is used if concerns were not resolved through the Agency or service provider's formal grievance process. This form should be sent to the New Mexico Human Services Department's Brain Injury Program no more than thirty (30) days after the date of the Agency or service provider's decision letter.

INSTRUCTIONS FOR THE PERSON FILING THE APPEAL:

Please fill in boxes 1-5. Then mail your appeal to the address noted in Box 6.
Box 7 will be filed in by the BISF Program Manager who gets the form.

Box 1: Fill in your name, date of birth, full address, phone and email. Also add the name of the BISF Service Coordination Agency you work with. If you do not have a SCA, write "N/A" in that space.
Box 2: Check the box for the agency who made the decision about your complaint.
Box 3: Tell us about the decision you are appealing.
Box 4: Tell us why you do not like the decision. Give your reasons for why you think the decision is wrong. Give any facts that support your case. If you have any records that support your case, you may send them too. Use more pages if needed.
Box 5: Sign and date.

If you need help with completing the form or in expressing your concerns, you may ask your Service Coordinator for contact information for a local advocacy agency. Or call the NM Brain Injury Resource Center (NMBIRC) at 1-844-366-2472. But call the NMBIRC only if the Appeal is not about a decision they made.

ROUTING:

Send the completed and signed form to:

Linda Gillet, Ph.D.
Brain Injury Program Manager
HDS/MAD/ESPB
PO Box 2348
Santa Fe, NM 87504

or

Email to: LindaB.Gillet@state.nm.us

FORM RETENTION:

Permanent

Flesch-Kincaid grade level: 5.8