



Home and Community Based Services-Adult Mental Health (HCBS-AMH)
No Reject Appeals Form

Individual Name (last, first, mi):	
CARE ID Number:	CMBHS ID:
Date of Birth:	Date of Discharge:
Legally Authorized Representative Name, if applicable: (last, first, mi)	

To be completed by the HCBS-AMH Provider:

<u>Current State Hospital of Residence:</u>
<u>State Hospital Point of Contact (Name, Title, Phone Number, Email). This individual should be able to provide relevant information on the individual and specific details surrounding current status:</u>
<u>Justification for denial of services. Please provide a summary outlining the reason(s) you are not able to support the individual in the community:</u>

Signature & Date – HCBS-AMH Provider

HCBS-AMH Provider Agency Contact

<i>For Internal Use Only</i>	
_____ HCBS-AMH Representative	_____ Date