Alabama Department of Mental Health

Division of Developmental Disabilities

APPEALS REQUEST FORM

Participant' Name:
Participant's Address:
Medicaid #:

If someone other than the participant is submitting this request, please fill out the information below:

Requestor Name:
Phone number:
Address (if different from participant's):
Email address:
Role/relationship to the participant: ☐ parent/guardian ☐ legal representative

☐ DHR representative ☐ other (specify) _____

Effective Date of Adverse Action: Click or tap to enter a date.

I hereby appeal the _____
(Adverse action)

_____

_____

My reason for requesting the appeal is:

_____

_____

_____

I understand that if currently receiving services, I may continue to receive my current level of service pending my appeal decision. Therefore, I request an Informal Conference to ADMH-DD for review of this matter.

This form must be received by the Office of Waiver Appeals within 15 calendar days of the effective date on the Notice of Adverse Action. Please submit this form via email to ddoaca.dmh@mh.alabama.gov or by mail to:

Alabama Department of Mental Health
Office of Waiver Appeals
P.O. Box 301410
Montgomery, AL 36130-1410