Timely Access & Notice of Adverse Benefit Determination (NOABD)

Medi-Cal Clients' Rights & Benefits
Presented by San Mateo BHRS Quality Management

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

V3.23.2021
Timely Access & Notice of Adverse Benefit Determination (NOABD)

Federal law (CFR 42 §438) and California law (CCR 9 §1810)

Consumer Problem Resolution and Notice of Adverse Benefits Determination Resolution System: BHRS POLICY: 19-01

DEFINITIONS

**Adverse Benefit Determination (ABD):** Any decision made by BHRS or its contractors that **denies, reduces, or terminates mental health services** to a beneficiary in-whole or in-part, including **denial of payment** and **failure to meet timeliness standards**, as outlined by the State.

**Beneficiary/Legal Representative:** An individual with **Medi-Cal coverage** or that individual’s legal representative (parent of minor, conservator, court/lawyer/social worker of minor removed from home). A legal representative is someone authorized to consent for the individual's treatment.

**Expedited Request or Appeal:** An expedited request for services or appeal of **Adverse Benefit Determination (ABD):** When BHRS determines, or provider indicates, that **taking the time for a standard decision or resolution could seriously jeopardize** the beneficiary’s **life, physical or mental health**, or ability to attain, maintain or regain optimal functioning.

The best way to check the client's insurance coverage is to ask your program's admin or the Billing MIS Department.
Another Way to Check Insurance in Avatar
DEFINITIONS

Request for Services - when a Medi-Cal beneficiary asks for covered service:
This may be a new client or returning client. Most of the time this requirement is for a new client; occasionally it is for a client asking for a different level of care. A new client is someone currently not open to any BHRS Medi-Cal program (includes CBOs).

The timeline starts the moment the client or representative requests services (for which they are legally able to authorize and accept services).

A request for services is made in the following ways:
1. A beneficiary/legal representative calls Call Center or other 24/7 ACCESS line.
2. A beneficiary/legal representative calls or walks into a clinic or provider site to request services.
3. A written request for services for a beneficiary is submitted via email, fax, letter, referral form, or authorization request. The timeline starts when the written request is received.
4. A client requests additional services from a current provider.
5. A provider requests services for a beneficiary/legal representative after their approval/agreement to make a referral.

DHCS FAQ: Regarding clients who are incarcerated: The request for service is not initiated until the client is legally able to accept services. Therefore, the request date is upon release/reconfirmation. Only appointments that are reimbursable under Medi-Cal (services provided during incarceration are not) count towards timely access.
All requests for assessment and/or services must be considered, and a decision must be made within 14 calendar days. (Expedited decisions are made within 72 hours). The decision may be to assess.

Services that require prior authorization must be reviewed and a decision must be made as expeditiously as the beneficiary’s mental health condition requires. This decision is not to exceed five (5) business days from the request and receipt of the information—that is reasonably necessary and requested by BHRS—to make the determination.

We may extend this process by 14 days if the client requests an extension or if we are waiting for information to make a decision.
The Medical Record

There must be **diligent**, **complete** and **timely documentation** of **every request for services** and all steps to consider requests.

**Always scan referral forms and emails with referrals into Avatar.**
No, all staff need to document requests for services in the client’s medical record (call log) and/or efforts to contact the client (in progress notes).

Poll Answer
Do only the clinical staff assigned to the client need to document the client’s request for services?
No

Poll Answer
Do we only open medical records for beneficiaries/clients after they consent for treatment and are assigned clinical staff?
No

No, we open the medical record (not an ICI episode) as soon as we get a request from a beneficiary/client, a person that can consent for the client’s care, or a provider if the provider indicates that the client is aware of and wants the referral. We don’t wait for signed consent and/or assignment of staff. If you receive a request for services from another provider and you are not sure if the client was aware of the request/referral, do not open a billing episode. Instead, you should document attempts to contact the client (to confirm their interest in services) in the ICI episode.
Documenting Requests for Services

Requests for services are documented in the Call Center Call Log and in Progress Notes.

Call Center Call Log
This is how we log requests for services.

Note: some teams use the initial contact information form. Ask your supervisor which form your team uses. A new CSI form will be coming soon.

Ask your program's admin or the Access Call Center to log your contact.
| Reason for referral, who referred client, date of initial request for service |
| Assessment appointment dates offered (3), and which offered appointments were accepted by the client |
| Efforts to reach the client |
| Whether or not the client meets Medical Necessity and will proceed to treatment |
| Offered treatment date(s) |
| Reason for closure of case or reason clinician could not follow up with client (e.g., “client is homeless and phone was disconnected”...etc.) |
We Must Conduct Timely ASSESSMENT & TREATMENT

Timely access standards for requested services:
- Non-urgent, non-psychiatry outpatient mental health/SUDS appointments - within 10 business days from request
- Non-urgent psychiatry appointments - within 15 business days from request
- Opioid treatment - within 3 business days from request

Expedited/Urgent Services:
- 48 hours for services not requiring preauthorization
- 96 hours for services that do require preauthorization

The assessment appointment counts as a first appointment. YES

If we offer AT LEAST 3 appointment(s) within the timeframe but the client does not accept the appointment(s), we are still in compliance. YES

If you complete the assessment, the client meets medical necessity, and you then put the client on a wait list, you need to issue a NOABD. YES
Treatment Decisions are Based on CLINICAL ASSESSMENT

01
ASSESSMENT OR ASSESSMENT REVIEW WITHIN THE FIRST 3 SESSIONS (WHEN POSSIBLE)

02
DETERMINE IF CLIENT MEETS MEDICAL NECESSITY (MN)

03
IF NO MEDICAL NECESSITY, ISSUE NOABD

04
IF CLIENT MEETS MN, DEVELOP TREATMENT PLAN WITH THE CLIENT (APPROVE SERVICES)

05
THEN, YOU MAY PROVIDE PLANNED SERVICES WITHIN TIMELY ACCESS MANDATES
Process for Issuing NOABD
Purpose of the NOABD

Informing the Medi-Cal beneficiary and provider:

- What we did (or if we did it on time)
- Exactly why we did it
- What they can do about it
- What their rights are and how we protect their rights

When possible, decisions should be communicated first by telephone or in person, then in writing (except for decisions rendered retrospectively).
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<tr>
<th>An Adverse Benefit Determination is defined to mean any of the following actions taken by BHRS (including CBOs):</th>
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<td>1. The <em>denial</em> or limited authorization of a <em>requested service</em> (based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit).</td>
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<td>2. The <em>reduction, suspension, or termination</em> of <em>previously authorized</em> service.</td>
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<td>3. The <em>denial</em>, in whole or in part, of <em>payment</em> for a service.</td>
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<td>4. The <em>failure</em> to provide <em>timely</em> services.</td>
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<td>5. The <em>failure</em> to act within required timelines for resolution of <em>grievances/appeals</em>.</td>
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<td>6. The <em>denial</em> of a beneficiary’s request to <em>dispute</em> financial liability.</td>
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Timing of Notice

C. Timing of the Notice
The Plan must mail the notice to the beneficiary within the following timeframes:  

1. For termination, suspension, or reduction of a previously authorized specialty mental health and/or DMC-ODS service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214; 
2. For denial of payment, at the time of any action denying the provider’s claim; or, 
3. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health and/or DMC-ODS services, within two business days of the decision.

The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

10 Title 42, CFR, Section 438.404(c) 11 Title 42, CFR, Section 431.211
Informing a Beneficiary about an Adverse Benefit Determination by BHRS (including CBOs)

Request for Service

Assessment and/or UM Screening Occurs

Decisions are made based on the assessment by licensed or registered staff

Assessment

Decision Time Frame

All requests for service must be considered and a decision must be made within required timeframe

Decision

Communicate

Communicate ABD

- Notice to Beneficiary, Parent/Legally Responsible Person: timelines vary depending on the type of NOABD (usually 2 days)
- Notice to affected provider: within 24 hours of decision
- Always send copy to BHRS QM
- Scan into EMR

Take Action

Send NOABD & Attachments
1. “Your Rights under Medi-Cal”
2. Beneficiary Non-Discrimination Notice
3. Language Assistance Taglines
4. Provide this link [https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx](https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx)

Send Notice

Request for Service for Medi-Cal Client

Any BHRS network of care provider receives a request for services (both MH & SUDS)
# Timelines for Mailing NOABDs to Beneficiary

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<td>Termination, suspension, or reduction of previously authorized SMHS/DMC-ODS service</td>
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Request for Service FAQ:

A Medi-Cal beneficiary calls a BHRS clinic and requests **primary care services** for a health issue. We refer the client to primary care and inform her that we do not provide primary care services for physical health.

**Answer: No**

**Explanation:**
We **do not need to issue a NOABD** for request for **non-covered** mental health or SUD services.

Just help the beneficiary connect with the needed services. Ask your admin to log this request in the Call Center Call Log.
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|       | - UM Teams (Adult/Youth)  
|       | - Clinician/Supervisor at Program  
|       | - CBO Conducting Assessment  
|       | - DMC-ODS Authorizer | • Beneficiary requests covered MH or SUDS service: BHRS denies/does not approve services after completing assessment  
|       |                    | • Denial-Based: Assessment determines no medical necessity, no qualifying diagnosis, level or type of service not appropriate, or service not effective for diagnosis |
Request for Service Scenario:

A beneficiary is assessed for specialty mental health services and does not meet criteria for medical necessity due to the diagnosis of Relational Problems, and it is decided that they will not receive specialty mental health services.

Answer: YES

Explanation:
We DO issue a NOABD Denial due to the beneficiary not meeting medical necessity.

Provide the beneficiary three community referrals if possible.
Request for Service Scenario:

The clinical team assessed the beneficiary for medical necessity. The beneficiary meets the medical necessity requirement.

The team offers to provide outpatient specialty mental health services including rehab groups, case management, and medication support, but the client requested therapy. We do not offer therapy.

Do we issue a Denial NOABD? What do you think? Yes or No

Answer: NO.

Explanation: We do not need to issue a NOABD. However, the beneficiary should participate in the development of the client plan. We should ensure that services, to the extent possible, are client-directed. A client who believes that additional services are necessary has the right to challenge our decision through the beneficiary appeal and State Fair Hearing processes.
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| Delivery System | Access Call Center  
SDA Clinician/Supervisor  
SDA CBO | **Beneficiary does not meet criteria for specialty mental health services or SUDS** but does meet criteria for other mental health/SUDS systems of care:   
• Mild to Moderate - referred to Health Plan of San Mateo (HPSM)  
• SED - referred to school district for mental health. |
Delivery System Scenario:

The client is screened at Same Day Assistance and it is determined that the beneficiary does not meet criteria to be eligible for specialty mental health services or substance use disorder (SUD) services through BHRS.

The client appears to have a more mild condition and we referred the beneficiary to HPSM for Mild to Moderate Services.

Do we issue a Delivery System NOABD?
What do you think? Yes or No

Answer: YES
Explanation:
We DO issue a NOABD for Delivery System and connect the client with HPSM.
## Notice of Adverse Benefit Determination (NOABD) Notices For Medi-Cal Beneficiaries

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<td>Access Call Center&lt;br&gt;UM Team/Coordinator (Adult/Youth)&lt;br&gt;CBO Conducting Assessment</td>
<td><strong>Beneficiary is already authorized for mental health treatment</strong> by BHRS Call Center or UM Teams (Adult/Youth)&lt;br&gt;• Reduced frequency and/or duration of authorized services</td>
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APPROVED SERVICES

VS.

AUTHORIZED SERVICES

Treatment Plans Approve Services

Planned services are approved by adding them to the client’s treatment plan.

Authorizations Authorize Services

Services requiring Authorizations require NOABDs if terminated, modified, or reduced during the authorized time block (once authorized).
If the service type does not require an authorization, a NOABD is not required when 1) client has approved Planned Services on the current treatment plan and 2) the Provider/Clinician decides to make changes because:

Changes are to the benefit of the client based on the client’s clinical condition and/or progress in treatment.

**Example of changes NOT subject to NOABD:**

The client will continue to receive services approved on the treatment plan with modifications (some changes will be made).

This applies to services like rehab, therapy, and groups:

- reduced in frequency (e.g., changed to monthly instead of weekly)
- modified service type (e.g., group is changed to rehab instead of therapy)
- or service is stopped/terminated (group or therapy is stopped)

If the client is unhappy, they may file a grievance or appeal the decision.
Authorized Services **ARE** Subject to NOABD

If an authorization is required for services and the authorization is granted:

Any reduction, suspension, or termination of a previously authorized service, while in the authorization timeframe, requires a NOABD.
Modification Scenario:

The client is approved for rehab group on the treatment plan.

However, the client disrupts the group weekly and upsets the other clients.

The group leader informs the client that she will no longer be able to participate in the group.

The client's other services are continued as normal and approved.

Do we issue Modification NOABD? What do you think? Yes or No

Answer: NO

Explanation:
We do NOT need to issue a NOABD for modifying services (approved on the treatment plan) that are in the best interests of the client. However, this is a clinical issue that should be addressed to help the client develop the skills to possibly rejoin the group at a later date. Document this in a progress note.
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| Delivery System    | Access Call Center<br>SDA Clinician/Supervisor<br>SDA CBO                          | **Beneficiary does not meet the criteria for specialty mental health services or SUDS** but does meet criteria for other mental health/SUDS systems of care:  
• Mild to Moderate - referred to Health Plan of San Mateo (HPSM)  
• SED - referred to school district for mental health |
| Modification       | Access Call Center<br>UM Team/Coordinator (Adult/Youth)<br>CBO Conducting Assessment | **Beneficiary is already authorized for mental health treatment** by BHRS call center or UM Teams (Adult/Youth)  
• Reduced frequency and/or duration of authorized services |
| Termination        | Access Call Center<br>UM Teams (Adult/Youth)<br>DMC-ODS Authorizer                | BHRS terminates or suspends a currently authorized service (or ends treatment that a client still wants)                                                                                                                   |
Termination Scenario 1:

The client successfully completes services as planned, in that either the treatment plan or authorization period ends as planned.

Do we issue a Termination NOABD? What do you think? Yes or No

Answer: NO

Explanation:
If the client successfully completes treatment and is not wanting additional services, we do not need to issue a NOABD.

Document your client’s care and discharge in a progress note.
Termination Scenario 2:
The client is lost to follow-up; you try but can’t get the client to respond to your outreach efforts. This is unplanned but the client seems to have withdrawn or given up on treatment.

The treatment plan and/or authorization is now expired.

Do we issue a Termination NOABD? What do you think? Yes or No

Answer: NO
Explanation:
If you do not discharge the client prior to the treatment plan and/or authorization ending, you do not need to issue a NOABD but you should document outreach calls and send call/close letter.

If you discharge the client prior to the end date of the treatment plan and/or authorization, issue a NOABD Termination.
Termination Scenario 3:
The client meets medical necessity, is participating in services, and wants services.

The client does not follow the clinic/program’s rules and the clinic terminates all services and discharges the client due to the client’s behavior.

The client still wants services.

Do we issue a Termination NOABD? What do you think? Yes or No

Answer: YES
Explanation:
If you discharge a client that meets medical necessity and still wants services, issue a NOABD Termination. Make sure that you make all efforts to help the client be successful.
If you move the client’s treatment location or transfer the client to another clinic and the client does not want that, issue either a NOABD Termination or Modification.
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### Timely Access

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<td>Timely access standards not met for FIRST ASSESSMENT APPOINTMENT And/or TREATMENT&lt;br&gt;Not OFFERED APPOINTMENT DATE or Placed client on WAITLIST within&lt;br&gt;- MH/SUDS OP within 10 business days from request.&lt;br&gt;- MED SUPPORT within 15 business days from request&lt;br&gt;- Opioid treatment within 3 business days&lt;br&gt;&lt;br&gt;Urgent Services: if not OFFERED APPOINTMENT WITHIN&lt;br&gt;- 48 hours for services not requiring preauthorization.&lt;br&gt;- 96 hours for services that do require preauthorization</td>
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If we are adding another program at the same level of care, and continuing the old program until the transition or addition, and it takes longer than the required timeframe, we don’t need to issue a NOABD.

Example: the client is open to South Adult; we add Total Wellness.
Timely Access Scenario:
A beneficiary is referred to a mental health clinic. The beneficiary has Medi-Cal, wants services, and has been diagnosed in the recent past with a covered diagnosis. The clinical staff are currently maxed out on case assignments and a few staff are on leave.

The program supervisor opens the beneficiary in their ICI episode (clinic's informal waitlist) to stop the documentation timeline.

Do we issue a Timely Access NOABD?
*What do you think? Yes or No*

Answer: **YES**
Explanation:
We do need to issue a NOABD Timely Access if we are unable to offer assessment or treatment within the required timeframes.

Also, just opening an ICI episode or waiting to open the chart does not stop the documentation timelines.
Timely Access Scenario:

A beneficiary is referred to a mental health clinic SDA by a primary care provider. It is unknown if the individual wants mental health treatment, but the PCP thinks that it is a good idea. The clinic team tries to contact the beneficiary many times with no luck.

Do we issue a Timely Access NOABD?
What do you think? Yes or No

Answer: NO
Explanation: We do NOT need to issue a NOABD Timely Access because we don’t really know if we have a beneficiary who wants services.

All efforts should be made to contact the individual. Document this in a progress note and in the Call Center Call Log.
Timely Access Scenario:

A beneficiary requests medication support services. The program staff offer a first appointment to the beneficiary 30 business days from receiving the referral.

Do we issue a Timely Access NOABD?
What do you think? Yes or No

Answer: YES
Explanation: We do need to issue a NOABD Timely Access because we did not meet the required timeframe for that level of care.
### Criteria for Beneficiary Notice

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Not OFFERED APPOINTMENT DATE or Placed client on WAITLIST within  
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• MED SUPPORT - within 15 business days from request  
• Opioid treatment - within 3 business days  
Urgent Services: if not OFFERED APPOINTMENT within  
• 48 hours for services not requiring preauthorization.  
• 96 hours for services that do require preauthorization |
| **Authorization Delay** | Access Call Center<br>UM Team/Coordinator (Adult/Youth)<br>Clinician/supervisor at Program<br>CBO Agency | If Authorization decision is not made on time:  
• Updates on this to come. Contact Ask QM if you have any questions about issuing this NOABD. |
Request for Authorization Delay:

UM staff receives an authorization request from an organizational provider but is unable to provide an authorization decision within 14 days.

Do we issue an Authorization Delay NOABD?
What do you think? Yes or No

Answer: YES
Explanation: We do need to issue a NOABD if we are unable to meet the authorization timeframes.
What Happens if the Client is not Happy?

- The client/beneficiary can talk with Supervisor or Manager.
- The client/beneficiary can appeal Adverse Benefit Determination (ABD).
- The client/beneficiary can file a grievance or get help.
- The client/beneficiary can contact Office of Consumer and Family Affairs (OCFA) 1-800-388-5189.
- The client/beneficiary can file a State Fair Hearing.
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Fillable forms are located at https://www.smchealth.org/bhrs-policies/consumer-problem-resolution-noa-19-01
CONSUMER PROBLEM RESOLUTION & NOA: 19-01

Client Rights

CONSUMER PROBLEM Resolution & NOA: 19-01 Policy 19-01
SUPERSEDES: 04-10 Notice of Action, 03-03 Consumer Problem Resolution System

ATTACHMENTS:
A. Consumer Problem Resolution (Grievance) and Notice of Adverse Benefits Determination (NOAB) User Manual
B. Grievance and Appeals System Usage Matrix How To Guide
C. NOAB Denial Notice English Spanish Tagalog Cantonese Mandarin
D. NOAB Modification Notice English Spanish Tagalog Cantonese Mandarin
E. NOAB Terminations Notice English Spanish Tagalog Cantonese Mandarin
F. NOAB Delivery System Notice English Spanish Tagalog Cantonese Mandarin
G. NOAB Authorization Delay English Spanish Tagalog Cantonese Mandarin
H. NOAB Timely Access Notice English Spanish Tagalog Cantonese Mandarin
I. NOAB Financial Liability Notice English Spanish Tagalog Cantonese Mandarin
J. NOAB Payment Denial Notice English Spanish Tagalog Cantonese Mandarin
K. NOAB Grievance and Appeal Timely Resolution Notice English Spanish Tagalog Cantonese Mandarin
L. NAR (Notice of Appeals Resolution) NOAB Overturned Notice English Spanish Tagalog Cantonese Mandarin
M. NAR (Notice of Appeals Resolution) NOAB Upheld OCFA English Spanish Tagalog Cantonese Mandarin
N. Notice of Grievance Resolution OCFA English Spanish Tagalog Cantonese Mandarin
O. NOAB Your Rights English Spanish Tagalog Cantonese Mandarin
P. NAR (Notice of Appeals Resolution) Your Rights English Spanish Tagalog Cantonese Mandarin
Q. Language Assistance Taglines
R. Beneficiary Non-Discrimination Notice English Spanish Tagalog Cantonese Mandarin
S. Grievance and Appeals Resolution Poster English Spanish Chinese Tagalog Russian
T. Grievance and Appeals Resolution Brochure English Spanish Chinese Tagalog
<table>
<thead>
<tr>
<th>NOABD</th>
<th>Responsible Staff</th>
<th>Criteria for Beneficiary Notice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Liability Notice</td>
<td>MIS</td>
<td>BHRS MIS/Billing denies a client’s request to dispute financial liability for services provided.</td>
</tr>
</tbody>
</table>
| Payment Denial Notice | MIS/UM            | When BHRS Billing Dept. Denies—in whole or in part for any reason—a request for payment for services already delivered to the beneficiary because:  
  • Condition as described by provider did not meet medical necessity criteria for DMC-ODS, psychiatric inpatient hospital services, or specialty MH services.  
  • Services provided are not covered by BHRS.  
  • BHRS MIS/QM requested but has not received additional information from the provider needed to approve payment.  
  • Provider did not meet documentation standards. |
| Grievance/Appeal Delay | OCFA              | The Plan does not meet required timeframes for the standard resolution of grievances and appeals.                                                                                                                               |
Payment Decisions are Based on POLICY

01
DETERMINE IF PAYMENT IS REQUIRED

02
IF NO MEDICAL NECESSITY, ISSUE NOABD TO CLIENT WITHIN REQUIRED TIMELINE AND TO PROVIDER WITHIN 24 HOURS

03
SEND COPY OF NOABD TO QM

04
45 poll
Alert:
COMING SOON to Avatar

A new form is being built in Avatar for creating NOA and grievance letters
If you want to consult about YOUR program’s requirements, let us know.

Thank you!

EMAIL YOUR QUESTION OR REQUEST FOR CONSULTATION TO HS_BHRS_ASK_QM@SMCGOV.ORG