Lanterman Act Appeal Request Form

DS 1821 (Rev. 09/2023)

This form is used to appeal Lanterman Act eligibility and services. This form is NOT used for Early Start or Vendor appeals.

HOW TO FILE AN APPEAL:

- The fastest way to file an appeal is electronically at the Department of Developmental Services (DDS) website: https://bit.ly/DDSAppealForm

OTHER WAYS TO SUBMIT AN APPEAL:

- You may send the attached form by email to AppealRequest@dds.ca.gov
- You may send the attached form by mail to 1215 O Street MS 8-20, Sacramento, CA 95814
- You may send the attached form by fax to 916-654-3641

TIMELINES FOR APPEALS:

You must file your appeal request on time. All appeal requests must be postmarked or received by DDS no later than 60 days after the date you got the Notice of Action (NOA) or Good faith Belief Letter (GFBL). There are two deadlines.

- The first deadline is for if you want to keep your current services the same during your appeal:
  - Your request must be postmarked or received by DDS no later than 30 days from when you received your NOA or GFBL, and before the action takes place.
    - Keeping your current services during an appeal is called aid paid pending.
- The second deadline is if your appeal request is postmarked or received by DDS 31 to 60 days from when you got your NOA or GFBL. An appeal that is filed within 31 to 60 days will be processed, but aid paid pending will not be granted.

WHERE TO GET HELP WITH YOUR APPEAL:

- Your service coordinator or other regional center staff, if you ask them.
- Your clients' rights advocate (CRA) at:
  - (800) 390-7032 for Northern California, (866) 833-6712 for Southern California, or
  - Find the clients' rights advocate at your regional center here.
- The Ombudsperson Offices at (877) 658-9731 or ombudsperson@dds.ca.gov, or online here.
  - If you are in the Self-Determination Program, please email sdp.ombudsperson@dds.ca.gov or you may go online instead.
- The State Council on Developmental Disabilities (SCDD). To find your local SCDD office, select "Regional Offices" at the top of this webpage: www.scdd.ca.gov and then choose your area. You also can reach them at (833) 818-9886.
- Disability Rights California (DRC) at:
  - 1-800-776-5746, 1-800-719-5798 for TTY, or you can complete DRC's online intake form.
  - DRC is available Monday, Tuesday, Thursday, and Friday from 9:00AM – 3:00PM
- You also may get help from a Family Resource Center: https://frcnca.org/get-connected/.
- Your regional center may help you find a local parent support group or community-based organization that can help you.

The "Appeals Information Packet" is found using the QR code or the link. They provide additional information about the appeal process.	https://bit.ly/AppealInfoPacket

Confidential Client Information, California Welfare and Institutions Code Sections 4514 and 5328, Health Insurance Portability and Accountability Act

* Required Fields

***What regional center is this appeal about?**

INFORMATION ABOUT THE PERSON RECEIVING OR SEEKING REGIONAL CENTER SERVICES:

***First Name:** ***Last Name:** ***Date of Birth:** **Unique Client Identifier (UCI)**

***Street Address:** **Apartment number:**

***City:** ***Zip:**

Primary Phone Number:
Primary Phone Number Type: ☐ Cell ☐ Home ☐ Work
Are text messages okay? ☐ Yes ☐ No (Data charges may apply)

Secondary Phone Number:
Secondary Phone Number Type: ☐ Cell ☐ Home ☐ Work
Are text messages okay? ☐ Yes ☐ No (Data charges may apply)

Email Address:

***How do you prefer we contact you?** ☐ Phone Call ☐ E-Mail ☐ Text Message

***What language do you prefer?** ***Do you need an interpreter?** ☐ Yes ☐ No

IF YOU ARE REQUESTING AN APPEAL FOR SOMEONE ELSE, PROVIDE YOUR INFORMATION HERE:

First Name: **Last Name:**

Relationship to person the appeal is for:
☐ Parent of a minor child ☐ Conservator ☐ Guardian
☐ Family Member ☐ Legal Advocate ☐ Other:
☐ Authorized Representative ☐ Attorney

Street Address: **Apartment number:**

City: **Zip Code:**

Primary Phone Number:
Primary Phone Number Type: ☐ Cell ☐ Home ☐ Work
Are text messages okay ☐ Yes ☐ No (Data charges may apply)

Secondary Phone Number:
Secondary Phone Number Type: ☐ Cell ☐ Home ☐ Work
Are text messages okay ☐ Yes ☐ No (Data charges may apply)

Email Address:

How do you prefer we contact you? ☐ Phone Call ☐ E-Mail ☐ Text Message

***What language do you prefer?** ***Do you need an interpreter?** ☐ Yes ☐ No

Confidential Client Information, California Welfare and Institutions Code Sections 4514 and 5328, Health Insurance Portability and Accountability Act

WHY ARE YOU REQUESTING AN APPEAL?

***Did you receive a document from the regional center that you would like to appeal?**

☐ Notice of Action (NOA) ☐ Good Faith Belief Letter (GFBL) ☐ Neither

If you received a NOA, what date did you receive it?

***Proposed action being taken by the regional center:**
(Check all that apply)

☐ **Eligibility Denial:**	You were notified by a regional center that you are not eligible for regional center services under the Lanterman Act. (This is not for Early Start eligibility).
☐ **Eligibility Termination:**	You currently are receiving regional center services, and you were notified that you are no longer eligible. This could be because you were reassessed and determined to be ineligible for regional center services.
☐ **Service Denial:**	You requested a new service, and the request was denied by your regional center.
☐ **Service Reduction:**	You were notified by your regional center that you will be receiving less of a current service.
☐ **Service Termination:**	You were notified by your regional center that you will no longer receive one or more of your current services.

What is the proposed effective date of the regional center action?

***Reason(s) for this Appeal:**

Confidential Client Information, California Welfare and Institutions Code Sections 4514 and 5328, Health Insurance Portability and Accountability Act

HOW WOULD YOU LIKE TO TRY TO RESOLVE YOUR APPEAL?

The appeal process has three parts. You may use one or more of these parts. If you don't resolve your disagreement using one part, you may decide to use other parts later.

***Choose the parts you want to use below:**
Note: If you select video below, you must supply an email address.

☐ **Informal meeting**	You meet with the regional center director or someone they choose. You and the regional center will try to resolve your appeal. **I want my informal meeting to be:** ☐ In person; ☐ by video; and/or ☐ by telephone
☐ **Mediation**	You and the regional center meet with a mediator. The mediator does not work for the regional center, or DDS. The mediator helps you and the regional center make an agreement about your appeal. **I want my mediation to be:** ☐ In person; ☐ by video; and/or ☐ by telephone
☐ **Hearing**	Your hearing is with a Hearing Officer. The Hearing Officer does not work for the regional center, or DDS. The Hearing Officer listens to information from you and the regional center, and helps you bring out your facts. Then the Hearing Officer makes a decision about the issues in your appeal request. **I want my hearing to be:** ☐ In person; ☐ by video; and/or ☐ by telephone

DATES/TIMES NOT AVAILABLE:

Please write any dates and times you are not available within the next 90 days so that your informal meeting, mediation, or hearing is not scheduled during those dates and times:

SIGNATURE SECTION:

The person submitting this form must sign and date in the space below. You may sign this form in ink or electronically. By typing your name, you agree that you have electronically signed this form.

***Signature:**

***Printed Name:**

***Date Signed:**

***If you would like to authorize someone to represent you in your appeal, or if you are requesting this appeal on behalf of another adult, please complete the attached Representative Authorization Form.**

Your rights during the appeal process were provided with your NOA or GFBL, and can be found here: https://www.dds.ca.gov/wp-content/uploads/2023/03/Appeal-Rights-March-2023-1.pdf

Confidential Client Information, California Welfare and Institutions Code Sections 4514 and 5328, Health Insurance Portability and Accountability Act

Representative Authorization Form

DS 1819 (Rev. 12/2023)

WHAT IS THIS FORM FOR?

This form is used to give permission to share personal information about you (the person who is seeking or receiving regional center services). It also can be used to give someone permission to represent you in a consumer rights complaint or service appeal. This is different from an Authorized Representative that is appointed by the State Council of Developmental Disabilities (SCDD) or a court.

Parents of a minor child, conservators, or legal guardians of persons seeking or receiving regional center services do not need to complete this form to give permission to themselves. They already have legal permission. However, they may use this form to give permission to someone else to represent you in a consumer rights complaint or service appeal. Proof of relationship to the person seeking or receiving regional center services may need to be provided later.

The different types of consumer rights complaints and service appeals are:

- Early Start Complaint – When you disagree with a service or eligibility decision or believe the rights have been violated for a child from birth until the age of three.
- Lanterman Service Appeal – When you disagree with a Lanterman service or eligibility decision proposed by a regional center.
- 4731 (Consumer Rights Complaint) – When you believe your rights have been violated by a regional center or a service provider. These complaints are not about services or eligibility.

WHERE TO GET HELP

- Your service coordinator or other regional center staff, if you ask them.
- Your clients' rights advocate (CRA) at:
  - (800) 390-7032 for Northern California, or
  - (866) 833-6712 for Southern California, or
  - Find the clients' rights advocate at your regional center here.
- The Ombudsperson Offices at (877) 658-9731 or ombudsperson@dds.ca.gov, or find more information online here.
  - If you are in the Self-Determination Program, please email: sdp.ombudsperson@dds.ca.gov or find more information online here.
- The State Council on Developmental Disabilities (SCDD). To find your local SCDD office, select "Regional Offices" at the top of this webpage: www.scdd.ca.gov and then choose your area. You also can reach SCDD at (833) 818-9886.
- Disability Rights California (DRC) at:
  - 1-800-776-5746
  - 1-800-719-5798 for TTY call
  - You also can complete DRC's online intake form.
- You also may get help from a Family Resource Center: https://frcnca.org/get-connected/.
- Your regional center may help you find a local parent support group or community-based organization that can help you.

Confidential Client Information, California Welfare and Institutions Code Sections 4514 and 5328, Health Insurance Portability and Accountability Act

Case Number: _____
(Internal Use Only)

* Required Fields

INFORMATION ABOUT THE PERSON RECEIVING OR SEEKING REGIONAL CENTER SERVICES:

***First Name:** ***Last Name:** ***Date of Birth:** **Unique Client Identifier (UCI)**

***Regional Center:**

WHAT DO YOU WANT REPRESENTATION FOR? (You may select more than one option)

☐ Consumers' Rights Complaint (4731)
☐ Early Start Complaint
☐ Lanterman Service or Eligibility Appeal
☐ Other:

REPRESENTATIVE'S INFORMATION:

***First Name:** ***Last Name:**

***Relationship to person receiving or seeking regional center services:**

☐ Parent of an adult child
☐ Family Member
☐ Friend
☐ Legal Advocate
☐ Attorney
☐ Guardian
☐ Other:

***Street Address:** ***Apartment number:**

***City:** ***Zip Code:**

***Primary Phone Number:**

Primary Phone Number Type:
☐ Cell ☐ Home ☐ Work

Are text messages okay?
☐ Yes ☐ No
(Data Charges may apply)

Secondary Phone Number:

Secondary Phone Number Type:
☐ Cell ☐ Home ☐ Work

Are text messages okay?
☐ Yes ☐ No
(Data Charges may apply)

Email Address:

SIGNATURE SECTION:

By signing this form, I am giving written permission to the representative named above to receive information and/or represent the person receiving or seeking services, as identified above.

***Signature:** ***Printed Name:**

***Date Signed:**

If you are filling this form out on behalf of someone else, what is your relationship to the person receiving or seeking regional center services:

☐ Parent of minor child
☐ Conservator
☐ Legal Guardian
☐ Authorized Representative (*Appointed by a governing body such as the SCDD or a court)

Confidential Client Information, California Welfare and Institutions Code Sections 4514 and 5328, Health Insurance Portability and Accountability Act