KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
Consumer Representative Request

I _____ want to request help with a KCMHSAS matter:
Printed consumer name

The situation going on in my life is:
Please check the box:

	I was denied services by KCMHSAS
	I was denied psychiatric hospital services by KCMHSAS
	My services are going to be suspended, reduced, or terminated.
	I was denied an appropriate length of stay at the psychiatric hospital.
	I do not agree with the services I was authorized.
	Other

I want help to:
Please check the box:

	Request a second opinion	Because I want to be reassessed for the services I asked for.
	File an appeal	Because I do not agree with the decision reduce, suspend, terminate or increase my services.
	File an expedited appeal	Because I think my health or life may be in danger if my appeal is not done in 3 working days.

I give _____ permission to act on my behalf.
Printed name of Person/Agency/Provider

Signed: _____ Date: _____
☐ Consumer or ☐ Guardian or Parent

Signed: _____ Date: _____
☐ Person/Agency/Provider Representative

Received: _____ Date: _____
☐ KCMHSAS Customer Services Representative

TL 4/05