North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services MEU
801 Ruggles Drive – 2501 Mail Service Center - Raleigh, N.C. 27699-2501
(919) 855-4000

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary
for Health Policy and Medical Assistance

March 1, 2006

Re: Enhanced Mental Health Notices

Dear County Director of Social Services:

On **March 20, 2006**, the Division of Medical Assistance (DMA) and the Division of Mental Health (DMH), Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), in conjunction with all local management entities (LMEs), will facilitate the transition to new Medicaid services. Many recipients served in all disability groups by the DMH/DD/SAS will be affected by this change.

The following Medicaid services for children are being terminated or changed:

- Community Based Services (CBS) for children with a Mental Retardation/Developmental Disability (MR/DD) diagnosis will terminate.
- Community Based Services (CBS) and/or case management for children with a Mental Health/Substance Abuse (MH/SA) diagnosis will be changing to Community Support Services (CSS).
- Either Residential Treatment Services or Day Treatment Services for children will terminate. Medicaid has been paying for both of these services Medicaid can pay for only one of the services. The Medicaid recipient has the right to select which service he would like to continue and which service he would like to end.

The following Medicaid services for adults are being terminated or changed:

- Community Based Services (CBS) for adults that have a Mental Retardation/Developmental Disability (MR/DD) diagnosis will terminate.
- Community Based Services (CBS) and/or case management for adults that have a Mental Health/Substance Abuse (MH/SA) diagnosis will be changing to Community Support Services (CSS).
- Either Assertive Community Treatment Team (ACTT) services or Psychosocial Rehabilitation (PSR) services for adults will terminate. Medicaid has been paying for both of these services; Medicaid can pay for only one of these services. The Medicaid recipient has the right to select which service he would like to continue and which service he would like to end.

The following Medicaid services for children and adults are being terminated:

- Community Based Services (CBS) for recipients participating in the Community Alternatives Program for Mentally Retarded/Developmentally Delayed (CAP-MRDD) Waiver program.

The purpose of this letter is to provide information regarding the recipient notification process. Medicaid recipients receiving DMH/DD/SAS services will soon receive letters from the LMEs informing them how the transition will affect them. After **March 20, 2006**, certain service labels will change and certain services are excluded from being provided. All recipients receiving DMH/DD/SAS services require notification of the pending service definition changes, some of which may lead to due process (appeal) rights. The following sample notices are enclosed:

- Notice of Change to Community Support Services (CSS) for Children with a Mental Health/Substance Abuse (MH/SA) Diagnosis
- Notice of Change to Community Support Services (CSS) for Adults with a Mental Health/Substance Abuse (MH/SA) Diagnosis
- Notice for Children with a Mental Health/Substance Abuse (MH/SA) Diagnosis Receiving Community Based Services (CBS) and/or Case Management
- Notice for Adults with a Mental Health/Substance Abuse (MH/SA) diagnosis Receiving Community Based Services (CBS) and/or Case Management
- Notice for Adults with a Mental Retardation/Developmental Disability (MR/DD) Diagnosis Receiving Community Based Services (CBS)
- Notice to Children with a Mental Retardation/Developmental Disability (MR/DD) Diagnosis Receiving Community Based Services (CBS)
- Notice to Adults Receiving Assertive Community Treatment Team (ACTT) and Psychosocial Rehabilitation (PSR)
- Notice of Choice of Assertive Community Treatment Team (ACTT) or Psychosocial Rehabilitation (PSR)
- Notice for Children Receiving Residential/Day Treatment
- Reconsideration Request for Termination of Residential/Day Treatment Services for Children

Medicaid recipients receiving notices of change are encouraged to contact the LMEs to seek guidance concerning the best course of action. The LMEs will inform Medicaid recipients about the changes, how it affects them, the services available to them, and, if appropriate, the circumstances that allow them to file an appeal and maintain services during the appeal process. For department of social services reference, a LME contact information document is being enclosed.

Please be sure your staff is aware of the impact of this transition and the notices of change being mailed to affected Medicaid recipients. If you have any questions regarding this information, please contact your Medicaid Program Representative.

Sincerely,

L. Allen Dobson

LAD/cg

Enclosures: Enhanced Mental Health Notices
LME Contacts Document

**NOTICE OF CHANGE TO COMMUNITY SUPPORT SERVICES (CSS)
FOR CHILDREN WITH A MENTAL HEALTH/SUBSTANCE
ABUSE DIAGNOSIS (MH/SA)**

[Recipient Name]
[Recipient Address]
[Recipient MID #]:

Dear [insert recipient name or legally responsible person]:

Beginning **March 20, 2006**, Medicaid cannot pay for Community Based Services (CBS). Because your child has a mental health/substance abuse (MH/SA) diagnosis, your child will be getting a new service called Community Support Services (CSS). During the transition period from CBS to CSS and until an individualized review can be performed by the local management entity (LME), your child, effective **March 20, 2006**, will receive the same number of CSS units that he/she received of CBS and case management combined.

[Insert ONE of the options below and remove the header.]

OPTION 1:
In our notice to you dated [insert date], we told you that you have the right to select your child's provider. We did hear from you and understand that you have chosen [insert name of provider] to provide CSS. If this is incorrect, please contact our Customer Service at [insert telephone number]. As soon as we hear from you, we will make the necessary changes and confirm them in writing to you.

OR

OPTION 2:
In our notice to you dated [insert date], we told you that you have the right to select your child's provider. We did not hear from you. Therefore, we have selected [insert name of provider] to provide CSS for your child. If you wish to make a different selection, please contact our Customer Service at [insert telephone number]. As soon as we hear from you, we will make the necessary changes and confirm them in writing to you.

Sincerely,

[Name]
[Title]
[Telephone Number]

NOTICE OF CHANGE TO COMMUNITY SUPPORT SERVICES (CSS) FOR ADULTS WITH A MENTAL HEALTH/SUBSTANCE ABUSE (MH/SA) DIAGNOSIS

[Recipient Name]
[Recipient Address]
[Recipient MID #]:

Dear [insert recipient name or name of legally responsible person]:

Beginning **March 20, 2006**, Medicaid cannot pay for Community Based Services (CBS). Because you or the person for whom you are legally responsible have a mental health/substance abuse (MH/SA) diagnosis, you or the person for whom you are legally responsible will be getting a new service called Community Support Services (CSS). Beginning **March 20, 2006**, you or the person for whom you are legally responsible will receive CSS.

[**Insert ONE of the options below and remove the header**.]

OPTION 1:
In our notice to you dated [insert date], we told you that you have the right to select a provider. We did hear from you and understand that you have chosen [insert name of provider] to provide CSS. If this is incorrect, please contact our Customer Service at [insert telephone number]. As soon as we hear from you, we will make the necessary changes and confirm them in writing to you.

OR

OPTION 2:
In our notice to you dated [insert date], we told you that you have the right to select a provider. We did not hear from you. Therefore, we have selected [insert name of provider] to provide CSS for you. If you wish to make a different selection, please contact our Customer Service at [insert telephone number]. As soon as we hear from you, we will make the necessary changes and confirm them in writing to you.

Sincerely,

[Name}
[Title]
[Telephone Number]

NOTICE FOR CHILDREN WITH A MENTAL HEALTH/SUBSTANCE ABUSE (MH/SA) DIAGNOSIS RECEIVING COMMUNITY BASED SERVICES (CBS) AND/OR CASE MANAGEMENT

We are writing to you because our records show that your child is getting Community Based Services (CBS) and/or case management. N.C. Medicaid has been paying for CBS and/or case management for your child. But, as of **March 20, 2006**, Medicaid cannot pay for CBS.

The reason for this change is because the federal government will no longer let Medicaid pay for CBS. N.C. Medicaid has worked hard to find other services to meet your child's needs. For Medicaid recipients who have a mental health/substance abuse (MH/SA) diagnosis, there is a new service. This service is called Community Support Services (CSS). Community Support Services include case management services. This is why your child's separate case management services will be discontinued **March 19, 2006**.

Because your child has a mental health/substance abuse diagnosis, your child will be getting this new service. We are excited about this new service. We believe this new service is more flexible and that it should meet your child's needs better than CBS.

One of the changes that you will find is that your child will only have one service provider. In the past your child had a service provider for case management and one for CBS. This new service includes case management.

You have the right to select your child's provider. Please contact our Customer Service at [insert number] to discuss your child's new services and choice of provider. You should contact us **as soon as possible but no later than March 16, 2006**. If you do not contact us by **March 16, 2006**, to select the provider for your child's new Community Support Services, a provider will be selected in the interim until you make a provider selection.

Please contact our customer service at [insert telephone number]. They can give you more information and answer your questions.

Sincerely,

Name]
[Title]
[Telephone Number]

NOTICE FOR ADULTS WITH A MENTAL HEALTH/SUBSTANCE ABUSE (MH/SA) DIAGNOSIS RECEIVING COMMUNITY BASED SERVICES (CBS) AND/OR CASE MANAGEMENT

We are writing to you because our records show that you or the person for whom you are legally responsible are getting Community Based Services (CBS) and/or case management. N.C. Medicaid has been paying for CBS and/or case management for you or the person for whom you are legally responsible. But, as of **March 20, 2006**, Medicaid cannot pay for CBS.

The reason for this change is because the federal government will no longer let Medicaid pay for CBS. N.C. Medicaid has worked hard to find other services to meet your needs or those of the person for whom you are legally responsible. For Medicaid recipients who have a mental health/substance abuse (MH/SA) diagnosis, there is a new service. This service is called Community Support Services (CSS). Community Support Services includes case management services. If you or the person for whom you are legally responsible are receiving case management services, separate case management services will be discontinued **March 19, 2006**.

Because you or the person for whom you are legally responsible have a mental health/substance abuse diagnosis, you or the person for whom you are legally responsible will be getting this new service, Community Support Services. We are excited about this new service. We believe this new service is more flexible and that it should meet your needs or those of the person for whom you are legally responsible better than CBS.

One of the changes that you will find is that you will only have one service provider. In the past you had a service provider for case management and one for CBS. As we said above, this new service will include your case management.

You have the right to select the provider. Please contact our Customer Service at [insert number] to discuss the new services and choice of provider. You should contact us **as soon as possible but no later than March 16, 2006**. If you do not contact us by **March 16, 2006**, to select the provider for the new Community Support Services, a provider will be selected in the interim until you make a provider selection.

Please contact our customer service at [insert telephone number]. They can give you more information and answer your questions.

Sincerely,

[Name]
[Title]
[Telephone Number]

NOTICE FOR ADULTS WITH A MENTAL RETARDATION/DEVELOPMENTAL DISABILITY (MR/DD)
DIAGNOSIS RECEIVING COMMUNITY BASED SERVICES (CBS)

We are writing to you because our records show that you or the person for whom you are legally responsible are getting Community Based Services (CBS) and have a mental retardation/developmental disability (MR/DD) diagnosis. N.C. Medicaid has been paying for CBS for you or the person for whom you are legally responsible. But, as of **March 20, 2006**, Medicaid cannot pay for CBS. The reason for this change is because the federal government will no longer let Medicaid pay for CBS.

Medicaid asked the federal government to agree to pay for a new service for individuals with a mental retardation/developmental disability (MR/DD) diagnosis. The federal government would not agree to cover the new service. Because of this decision, the State of North Carolina has worked very hard over the past few months to develop services that will be available to you or the person for whom you are legally responsible when CBS ends. The case manager may have already contacted you to discuss some of the new services with you. The State of North Carolina intends that on **March 20, 2006**, even though CBS services will end in North Carolina, that every Medicaid eligible adult affected by this change will have other appropriate services in place.

It is the case manager's duty to assist individuals in selecting new services to meet their needs or those of the person for whom you are legally responsible. Some of the new services are paid for by Medicaid; some of the new services are paid for by the State of North Carolina.

Please contact our Customer Service at [insert telephone number]. They can give you more information.

Sincerely,

[Name]
[Title]
[Telephone Number]

NOTICE TO CHILDREN WITH MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES (MR/DD) DIAGNOSIS RECEIVING COMMUNITY BASED SERVICES

We are writing to you because our records show that your child has been getting Community Based Services (CBS). N.C. Medicaid has been paying for this service for your child. However, as of **March 20, 2006**, Medicaid will no longer pay for this service. The reason for this change is because the federal government will no longer let Medicaid pay for this service for any Medicaid recipient.

Medicaid asked the federal government to agree to pay for a new service for individuals with a mental health/developmental disability (MR/DD) diagnosis. The federal government would not agree to cover the new service. Because of this decision, the State of North Carolina has worked very hard over the past few months to develop services that will be available to your child when CBS ends. Your child's case manager may have already contacted you to discuss some of the new services with you. The State of North Carolina intends that on **March 20, 2006**, even though CBS will end in North Carolina, that every Medicaid eligible child affected by this change will have other appropriate services in place.

It is the case manager's duty to assist you in selecting new services for your child that will meet his/her needs. Some of the new services are paid for by Medicaid; some of the new services are paid for by the State of North Carolina.

Although the federal government would not agree to pay for the new services developed to treat individuals with a mental retardation/developmental disability diagnosis, the federal government did agree to pay for a new service, **Community Support Services (CSS)**, to treat individuals with a mental health/substance abuse (MH/SA) diagnosis. For individuals with a mental health/substance abuse diagnosis, this service will begin on **March 20, 2006**.

Our records show that based on your child's diagnosis, the service is **not** available to your child **UNLESS**:

1. Regardless of your child's diagnosis, CSS is medically necessary to correct or improve your child's condition,

OR

2. Your child DOES have a Mental Health or Substance Abuse diagnosis.

If you believe that either number one or two above describes your child or the person for whom you are legally responsible, you can ask N.C. Medicaid to reconsider its decision not to provide CSS to your child. If you ask for such a reconsideration, then while Medicaid reviews its decision, CSS will be provided for your child at the level your child was receiving CBS. If Medicaid finds that CSS is necessary to correct or improve your child's condition, it will continue to provide this service as long as necessary—assuming your child remains otherwise Medicaid eligible. If Medicaid decides that CSS is not medically necessary to correct or improve your child's condition, it will notify you in writing of its decision and will provide you with information about your rights, including how to appeal its decision.

If you are satisfied with the services your case manager helped you to select for your child, you do not need to do anything further. But, if you think that either number one or two above describes your child's situation, and you wish to have N.C. Medicaid reconsider its decision to end CBS and not switch your child to CSS, you may fill out the attached form and return it us on or before **March 18, 2006**.

You may call our Customer Service at [insert number] with any questions.

Sincerely,

[Name]
[Title]
[Telephone Number]

REQUEST TO RECONSIDER COMMUNITY SUPPORT SERVICES (CSS)

□ CSS is necessary to correct or improve my child's condition or your records fail to show my child has a mental health/substance abuse (MH/SA) diagnosis. By signing and returning this form, I am requesting that N.C. Medicaid reconsider its decision that my child will not receive CSS beginning **March 20, 2006**. I understand this is a medical decision and that N.C. Medicaid may need information from my child's physician or licensed clinician to reconsider its decision. While N.C. Medicaid reconsiders its decision, I understand that my child will receive CSS instead of the new services my child's case manager has identified to replace CBS.

_____ _____

Signature of Recipient or Legally Responsible Person — Print Recipient Name

_____ _____

Print Name of Legally Responsible Person — Date

Did you **check** the box? Did you **sign** your name? Did you **fill** in the date? Did you **print** the names of the recipient and legally responsible person, if applicable?

Please return this form to our Customer Service at the address below. Customer Service must receive this form by **March 18, 2006**.

Customer Service
[insert address]
[insert telephone number]

You may call our Customer Service at [insert number] with any questions. If our Customer Service has **NOT** received this form by **March 18, 2006**, your child, beginning **March 20, 2006**, will receive the services the case manager has put together in his/her plan of care.

NOTICE TO ADULTS RECEIVING ASSERTIVE COMMUNITY TREATMENT TEAM (ACTT) AND PSYCHOSOCIAL REHABILITATION (PSR)

We are writing to you because our records show that you or the person for whom you are legally responsible are getting Assertive Community Treatment Team (ACTT) services and Psychosocial Rehabilitation (PSR) services. N.C. Medicaid has been paying for both services for you or the person for whom you are legally responsible. But, as of **March 20, 2006**, Medicaid can only pay for one of these services for you or the person for whom you are legally responsible. The reason for this change is because the federal government will no longer let Medicaid pay for both services for any Medicaid recipient.

Since Medicaid can only pay for one service, you or the person for whom you are legally responsible must select the service you or the person for whom you are legally responsible wish to continue. Below are two boxes. Please check one to show the service you or the person for whom you are legally responsible wish to continue. Please read the information carefully and make a choice.

□ I want **ACTT** services to **continue**. I understand my **PSR** services will **end**.

_____ _____
Signature of Recipient or Legally Responsible Person — Print Recipient Name

_____ _____
Print Name of Legally Responsible Person — Date

□ I want **PSR** services to **continue**. I understand my **ACTT** services will **end**.

_____ _____
Signature of Recipient or Legally Responsible Person — Print Recipient Name

_____ _____
Print Name of Legally Responsible Person — Date

Did you **check** a box? Did you **sign** your name? Did you **fill** in the date? Did you **print** the names of the recipient and legally responsible person, if applicable?

Please return this form to our Customer Service at the address below. Customer Service must receive this form by **March 16, 2006**.

Customer Service
[insert address]
[insert telephone number]

Instead of returning this form, you may call our Customer Service at [insert number] to tell us which service you wish to continue. Please call by **March 16, 2006**. We will mail a notice to you before **March 20, 2006**, confirming your choice of service. The notice will also contain information about how you can change your selection, if you wish.

If our Customer Service has **NOT** received your choice by **March 16, 2006**, we will choose **ACTT** for you or the person for whom you are legally responsible. This means that unless we hear from you by **March 16, 2006**, **PSR** will end **March 20, 2006**. Please contact us **no later than March 16, 2006**, with your decision.

If you have questions, please call [insert telephone number].

Sincerely,

[Name]
[Title]
[Telephone Number]

NOTICE FOR CHILDREN RECEIVING RESIDENTIAL/DAY TREATMENT

We are writing to you because our records show that your child receives BOTH residential treatment services and day treatment services. N.C. Medicaid has been paying for both services for your child. But, as of **March 20, 2006**, Medicaid will only pay for one of these services for your child UNLESS your child continues to need both services to correct or improve his/her condition or illness. The reason NC Medicaid is making this change is because the federal government has told NC Medicaid that it cannot pay for both services for a recipient, UNLESS BOTH ARE MEDICALLY NECESSARY TO CORRECT OR IMPROVE A CHILD'S CONDITION OR ILLNESS.

If you believe that your child will need to continue to receive both services to correct or improve his condition, please check the first box below. If, however, you believe that either residential or day treatment alone will satisfy your child's needs, then please check the correct box – either the second or the third box. Please read the information carefully and make your choice.

□ I want BOTH **Day Treatment Services and Residential Treatment Services** to continue for my child. I believe both services are necessary to correct or improve my child's condition. I understand that Medicaid will evaluate my child's need for both services. To reach a decision about my child's need for both services, N.C. Medicaid will need information from my child's doctor or a licensed psychologist that supports my request for both services.

□ I want my child's **Residential Treatment** services to continue. I understand my child's **Day Treatment** services will end.

□ I want my child's **Day Treatment** services to continue. I understand my child's **Residential Treatment** services will end.

_____ _____

Signature of Legally Responsible Person Print Your Name

_____ _____

Print Your Child's Name Date

PLEASE COMPLETE THIS FORM AND RETURN IT TO US BY MARCH 16!!!

If you check the first box above, your child will continue to receive both services while we conduct an individual review of your child's needs.

If you checked box two your child will continue to receive residential treatment services, but day treatment will end on March 19, 2006.

If you checked the third box, your child will continue to receive day treatment, but residential treatment will end on March 19, 2006.

Did you **check** a box? Did you **sign** your name? Did you **fill** in the date? Did you **print** your name and your child's?

Please return this form to our Customer Service at the address below. Customer Service must receive this form by **March 16, 2006**.

Customer Service
[insert address]
[insert telephone number]

Instead of returning this form, you may call our Customer Service at [insert number] to tell us of your choice. **You MUST contact us in writing or by phone by March 16, 2006**. If you call us, you will still need to return this form to us as soon as possible.

If you have questions, please call [insert telephone number].

Sincerely,

[Name]
[Title]
[Telephone Number]

NOTICE FOR COMMUNITY ALTERNATIVES PROGRAM FOR MENTALLY RETARDED/DEVELOPMENTALLY DELAYED(CAP-MRDD)WAIVER PARTICIPANTS RECEIVING COMMUNITY BASED SERVICES (CBS)

ADULTS AND CHILDREN

We are writing to you because our records show that you or the person for whom you are legally responsible are getting Community Based Services (CBS). N.C. Medicaid has been paying for CBS for you or the person for whom you are legally responsible. But, as of **March 20, 2006**, Medicaid cannot pay for CBS. The reason for this change is because the federal government will no longer let Medicaid pay for CBS.

N.C. Medicaid has worked hard to find other services to meet your needs or those of the person for whom you are legally responsible. You or the person for whom you are legally responsible are currently on the Community Alternatives Program for Mentally Retarded/Developmental Disability (CAP-MRDD) Waiver Program. The case manager will work with you to add more waiver services, as necessary, to meet your needs or those of the person for whom you are legally responsible. The State of North Carolina intends that on **March 20, 2006**, even though CBS services will end in North Carolina, that every Medicaid eligible recipient affected by this change will have other appropriate services in place.

Please contact our customer service if you have questions. Our number is [insert telephone number]. You may also contact the case manager.

Sincerely,

[Name]
[Title]
[Telephone Number]

CUSTOMER SERVICE AND CLIENT RIGHTS LOCAL OFFICES

Area Program/ LME	Client Rights	Complaints	Medicaid Appeals
Alamance-Caswell	Jane Peters Phone: (336) 513-4200 ext. 4118 Fax: (336) 513-4449 jpeters@acmhddsa.org	Jane Peters Phone: (336) 513-4200 ext. 4118 Fax: (336) 513-4449 jpeters@acmhddsa.org	Alicia Graham Phone: (336) 513-4200 Fax: (336) -513-4449 agraham@acmhddsa.org
Albemarle MH/DD/SAS	David Gilbert Phone: (252) 335-0803 ext. 10299 Fax: (252) 338-8352 davidg@albemarlemhc.org	David Gilbert Phone: (252) 335-0803 ext. 10299 Fax: (252) 338-8352 davidg@albemarlemhc.org	David Gilbert Phone: (252) 335-0803 ext. 10299 Fax: (252) 338-8352 davidg@albemarlemhc.org
Mental Health Services of Catawba County	Gail Henson Phone: (828) 327-2595 Fax: (828) 325-9826 GailHenson@catawbacountync.gov	Gail Henson or Melissa Cline (828) 327-2595 Fax: (828) 325-9826 GailHenson@catawbacountync.gov Melissac@catawbacountync.gov	Gail Henson or Melissa Cline (828) 327-2595 Fax: (828) 325-9826 GailHenson@catawbacountync.gov Melissac@catawbacountync.gov
Crossroads Behavioral Healthcare	Tim Harrison Phone: (336) 835-1000 Fax: (336) 835-1002 Tharrison@crossroadsbhc.org	David Crosby Phone: (336) 835-1000 Fax: (336) 835-1002 Dcrobsby@crossroadsbhc.org	Tim Harrison Phone: (336) 835-1000 Fax: (336) 835-1002 Tharrison@crossroadsbhc.org
Cumberland County Mental Health Center	Debbie Jenkins Phone: (910) 222-6354 Fax: (910) 678-9963 djenkins@mail.ccmentalhealth.org	Debbie Jenkins Phone: (910) 222-6354 Fax: (910) 678-9963 djenkins@mail.ccmentalhealth.org	Debbie Jenkins Phone: (910) 222-6354 Fax: (910) 678-9963 djenkins@mail.ccmentalhealth.org
The Durham Center	Carla Alston Phone: (919) 560-7256 Fax: (919) 560-7240 CAlston@co.durham.nc.us	Carla Alston Phone: (919) 560-7256 Fax: (919) 560-7240 CAlston@co.durham.nc.us	Carla Alston Phone: (919) 560-7256 Fax: (919) 560-7240 CAlston@co.durham.nc.us

Area Program/ LME	Client Rights	Complaints	Medicaid Appeals
Edgecombe-Nash MH/DD/SAS	Linda Hawley Phone: (252) 206-5000 Fax: (252) 206-5001 lhawley@wgmhc.com	Linda Hawley Phone: (252) 206-5000 Fax: (252) 206-5001 lhawley@wgmhc.com	Amy Cox Phone: (252) 206-5000 Fax: (252) 206-5001 acox@wgmhc.com
Five County MH/DD/SAS (includes Vance, Granville, Franklin, Warren and Halifax Counties)	Robin Wheatley Phone: (252) 430-1330 ext. 291 Fax: (252) 430-0909 rwheatley@fivecountymha.org	Robin Wheatley Phone: (252) 430-1330 ext. 291 Fax: (252) 430-0909 rwheatley@fivecountymha.org	Eva Brown Phone: (252) 430-1330 Ext 225 Fax: (252) 430-0909 ebrown@fivecountymha.org
Foothills MH/DD/SAS	Brian Shuping Phone: (828) 438-6278 ext. 6278 Fax: (828) 438-6230 brian.shuping@foothills-bhc.org	Brian Shuping Phone: (828) 438-6278 ext. 6278 Fax: (828) 438-6230 brian.shuping@foothills-bhc.org	Brian Shuping Phone: (828) 438-6278 ext. 6278 Fax: (828) 438-6230 brian.shuping@foothills-bhc.org
The Guilford Center	Grace Salgado Phone: (336) 641-6644 Fax: (336) 641-8026 GSalgado@GuilfordCenter.com	Grace Salgado Phone: (336) 641-6644 Fax: (336) 641-8026 GSalgado@GuilfordCenter.com	Susan Campbell Phone: (336) 641-6430 Fax: (336) 641-3655 Scampbell@guilfordcenter.com
Johnston County MH/DD/SAS	Angie Hinnant Phone: (919) 989-5500 Fax: (919) 989-5532 angie.hinnant@johnstonnc.com	Mary Kavanaugh Phone: (919) 989-5500 Fax: (919) 989-5532 mary.kavanaugh@johnstonnc.com	Patty McGaffagan Phone: (919) 989-5500 Fax: (919) 989-5532 patty.mcgaffagan@johnstonnc.com
Mecklenburg County MH/DD/SA Authority	Nancy Cody Phone: (704) 336-6027 Fax: (704) 336-7718 Codynan@mecklenburg.nc.us	Nancy Cody Phone: (704) 336-6027 Fax; (704) 336-7718 Codynan@mecklenburg.nc.us	Jason Randall Phone: (704) 336-7187 Fax: (704) 336-7718 Randadj@mecklenburg.nc.us

Area Program/ LME	Client Rights	Complaints	Medicaid Appeals
New River Behavioral Healthcare	Catherine Upchurch Phone: (828) 263-5650 Fax: (828) 264-3674 upchurch@newriver.org	Catherine Upchurch Phone: (828) 263-5650 Fax: (828) 264-3674 upchurch@newriver.org	Catherine Upchurch Phone: (828) 263-5650 Fax: (828) 264-3674 upchurch@newriver.org
Onslow- Carteret Behavioral Healthcare	Jessica Charters Phone: (910) 219-8012 Fax: (910) 219-8072 jessica_charters@ocbhs.org	Jo Warwick Phone: (910) 219-8009 Fax: (910) 219-8072 jo_warwick@ocbhs.org	Jo Warwick Phone: (910) 219-8009 Fax: (910) 219-8072 jo_warwick@ocbhs.org
Orange-Person-Chatham	Lynne Hamlet (919) 913-4079 Fax: 919-913-4038 Lhamlet@opc-mhc.org	Katherine Hudson (919) 913-4120 Fax: 919-913-4009 Khudson@opc-mhc.org	Lynne Hamlet (919) 913-4079 Fax: 919-913-4038 Lhamlet@opc-mhc.org
Pathways	Jerry Utt Phone: (704) 884-2575 Fax: (704) 854-4809 jutt@pathmhddsa.org	Jerry Utt Phone: (704) 884-2501 Fax: (704) 854-4809 jutt@pathmhddsa.org	Jerry Utt Phone: (704) 884-2501 Fax: (704) 854-4809 jutt@pathmhddsa.org
Piedmont Behavioral Healthcare	Bonnie Schell Phone: (704) 721-7000 Fax: (704) 721-7010 bschell@pamh.com	Jill Queen Phone: (704) 721-7015 Fax: (704) 721-7010 jqueen@pamh.com	MH/SA- Pam Rankin; DD- Andrea Misenheimer Phone: (704) 743-2100 Fax: (704) 743-2120 prankin@pamh.com; amisenheimer@pamh.com

Area Program/ LME	Client Rights	Complaints	Medicaid Appeals
Roanoke-Chowan Human Services Center	Regina Parker Phone: (252) 332-4137 Fax: (252) 332-8457 Regina.parker@ncmail.net	Wanda Piland Phone: (252) 332-4137 Fax: (252) 332-8457 Wanda.piland@ncmail.net	Wanda Piland Phone: (252) 332-4137 Fax: (252) 332-8457 Wanda.piland@ncmail.net
Rockingham County MH/DD/SAS	James Burston Phone: (336) 342-8417 Fax: (336) 342-8352 jburston@co.rockingham.nc.us	James Burston Phone: (336) 342-8417 Fax: (336) 342-8352 jburston@co.rockingham.nc.us	James Burston Phone: (336) 342-8417 Fax: (336) 342-8352 jburston@co.rockingham.nc.us
Sandhills MH/DD/SAS (includes Lee-Harnett)	Lynn Dodge Phone: (336) 633-7056 Fax: (336) 625-4969 lynn.dodge@sandhillscenter.org	Lynn Dodge Phone: (336) 633-7056 Fax: (336) 625-4969 lynn.dodge@sandhillscenter.org	Doug Litton Phone: (910) 673-1853 Fax: (910) 673-7805 douglasl@sandhillscenter.org
Smoky Mountain Center	Charley Barry Phone: (828) 586-5501 ext. 1121 Fax: (828) 586-3965 barrycharl@smokymountaincenter.com	Charley Barry Phone: (828) 586-5501 ext. 1121 Fax: (828) 586-3965 barrycharl@smokymountaincenter.com	Charley Barry Phone: (828) 586-5501 ext. 1121 Fax: (828) 586-3965 barrycharl@smokymountaincenter.com
Southeastern Center MH/DD/SAS	Julie Quisenberry Phone: (910) 796-3138 Fax: (910) 313-6022 quisen@secmh.org	Julie Quisenberry Phone: (910) 796-3138 Fax: (910) 313-6022 quisen@secmh.org	Becky Page Phone: (910) 796-3104 Fax: (910) 796-3100 pageb@secmh.org

Area Program/ LME	Client Rights	Complaints	Medicaid Appeals
Tideland Mental Health Center	Mona Freeperson Phone: (252) 975-4695 ext 2213 Fax: (252) 946-1537 mfreeperson@tideland.org	Mona Freeperson Phone: (252) 975-4695 ext 2213 Fax: (252) 946-1537 mfreeperson@tideland.org	Mona Freeperson Phone: (252) 975-4695 ext 2213 Fax: (252) 946-1537 mfreeperson@tideland.org
Wake County Human Services	Kathleen Nilsson Phone: (919) 212-7838 Fax: (919) 212-7139 knilsson@co.wake.nc.us	Consumer Rights Phone Phone: (919) 212-7155	Kathleeen Nilsson Phone: (919) 212-7838 Fax: (919) 212-7193 knilsson@co.wake.nc.us
Western Highlands	Lynn Trotter Phone: (828) 225-2800 ext. 2998 Fax: (828) 252-2784 lynn@westernhighlands.org	Lynn Trotter Phone: (828) 225-2800 ext. 2998 Fax: (828) 252-2784 lynn@westernhighlands.org	Lynn Trotter Phone: (828) 225-2800 ext. 2998 Fax: (828) 252-2784 lynn@westernhighlands.org
Wilson-Greene MH/DD/SAS	Linda Hawley Phone: (252) 206-5000 Fax: (252) 206-5001 lhawley@wgmhc.com	Linda Hawley Phone: (252) 206-5000 Fax: (252) 206-5001 lhawley@wgmhc.com	Amy Cox Phone: (252) 206-5000 Fax: (252) 206-5001 acox@wgmhc.com