



## Tennessee Department of Children's Services

# Child and Family Team Meeting Summary

Meeting Date: \_\_\_\_\_ Meeting Time: \_\_\_\_\_ Type of CFTM: \_\_\_\_\_

Location: \_\_\_\_\_ TennCare Appeal Rights Explained: ☐ Yes ☐ No

### Confidentiality Agreement:

During the Child and Family Team Meeting we ask that all participants respect the family's privacy. Sensitive issues may be discussed and we want everyone to feel safe to express their opinions or voice their concerns. DCS has an obligation to keep information related to child abuse or neglect confidential from public disclosure. However, the confidentiality of information shared at a Child and Family Team Meeting cannot be guaranteed. There are circumstances when information discussed may be shared in order to make informed decisions about placement, services, treatment and/or permanency for child(ren). DCS must comply with the request of the court to supply information.

Please be advised that DCS is required to report any information related to:

- New allegations or suspicions of the abuse or neglect of a child
- If someone threatens to harm himself or herself
- If a direct threat is made against another party

We trust that all participants agree to safeguard the privacy of this family and what is discussed during the meeting.

- ☐ By checking this box, the facilitator indicates that they reviewed the Confidentiality Agreement with the team at the beginning of this meeting.
- ☐ By checking this box, the facilitator indicates that the participants agree the CFTM Summary may be shared with all team members, including those who may not be present at this meeting.

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)




**Family Story:** What is the family saying about why we are here, what are their needs/strengths, what do they want to see happen?

**Diligent Search:** Is there any new information available on absent/uninvolved parents, grandparents, adult relatives or significant kin at this time? What efforts have been made to locate, contact, or engage them?

**Concurrent Planning:** Was there a discussion about the appropriateness of adding a concurrent goal? If so, what was discussed?

**Worker Observation(s)/Additional Information:**

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

**Educational Stability:**

Did this meeting result in an entry into foster care or placement change? ☐ Yes ☐ No

If yes, a Best Interest Determination Meeting with the school system to ensure educational stability may be required. Please mark the checkbox that best explains the circumstances of this youth/ child.

- ☐ The new placement is within a one hour drive from the school the child/youth is currently enrolled. A Best Interest Determination (BID) Meeting with school personnel is required under guidance from the Every Student Succeeds Act to determine if it is in the best interest for the child/youth to remain in the school they are currently enrolled or transfer to the new school of zone. Who will notify the Education Specialist of the need for a BID Meeting? \_\_\_\_\_
- ☐ The new placement is over an hour drive from the current school and it is not feasible for the child/youth to remain in the school of origin. The child/youth will be enrolled in the new school immediately.
- ☐ The child/youth will attend school in a treatment facility and does not require a BID meeting regardless of the distance from the current school.
- ☐ There is a safety risk/concern/treatment need identified by the Child and Family Team that suggests it is not in the child/youth's best interest to remain in the school of origin. Consultation with the Education Specialist will occur to determine if a BID Meeting is needed based on those special circumstances. Who will consult with the Education Specialist? \_\_\_\_\_
- ☐ A new placement is needed for the child/youth, but one has not been identified at this time. Once the placement is identified, the assigned worker will determine next steps as outlined in the options above.

To create and support educational stability for children/youth in foster care when placement change occurs, the team should review, consider the assurances listed below. By marking the following checkboxes, the Child and Family Team assures:

- ☐ When determining placement, the team considered the appropriateness of the current educational setting and the proximity to the school the child/youth was enrolled at the time of placement.
- ☐ As indicated above, DCS will coordinate with the local education agency to ensure the child/youth can remain in the school of origin if it is in the child/youth's best interest. If it is not in the child/youth's best interest to remain in the school of origin, DCS will immediately enroll the child/youth into a new school with all of his or her available educational records.

Other information to consider when planning for educational stability for this child/youth:

**Strengths Discussed:**

Person Concerning: \_\_\_\_\_

Strength Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

Person Concerning: \_\_\_\_\_

Strength Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

Person Concerning: \_\_\_\_\_

Strength Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

Person Concerning: \_\_\_\_\_

Strength Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

Person Concerning: \_\_\_\_\_

Strength Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

Person Concerning: \_\_\_\_\_

Strength Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

### **Needs Discussed**

Child and Family History of Trauma/Adverse Experiences:

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

Child and Family Recent and/or Ongoing Trauma/Adverse Experiences:

**Visitation Needs/Concerns**

Person Concerning: \_\_\_\_\_

Need Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

Responsibilities	Responsible Party	Start Date	End Date

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

Progress/Update Status:

Needs/Concerns

Person Concerning:

Need Category:

Start Date:

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

Responsibilities Responsible Party Start Date End Date

--	--	--	--

Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)


**Progress/Update Status:**

**Needs/Concerns**

Person Concerning: \_\_\_\_\_

Need Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

**Responsibilities**

**Responsible Party**

**Start Date**

**End Date**


*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)


**Progress/Update Status:**

**Needs/Concerns**

Person Concerning: \_\_\_\_\_

Need Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

**Responsibilities**

**Responsible Party**

**Start Date**

**End Date**


*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

Progress/Update Status:

Needs/Concerns

Person Concerning: \_\_\_\_\_

Need Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

Responsibilities	Responsible Party	Start Date	End Date

Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

Progress/Update Status:

Needs/Concerns

Person Concerning: \_\_\_\_\_

Need Category: \_\_\_\_\_

Start Date: \_\_\_\_\_

Current Description

Social, Medical & Educational Needs Addressed: ☐ Yes ☐ No

Independent Living/Transition Plan ☐ Yes ☐ No

**Responsibilities**                                      **Responsible Party**                                      **Start Date**                                      **End Date**


*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

**Progress/Update Status:**

Next Meeting Date: \_\_\_\_\_

Time: \_\_\_\_\_

Family Members are encouraged to contact DCS at any time as needed for services, questions or concerns. You may contact your worker or their supervisor for assistance.

My Family Service Worker is \_\_\_\_\_ and his/her phone number is \_\_\_\_\_

Their Team Leader is \_\_\_\_\_ and his/her phone number is \_\_\_\_\_

Did Everyone Agree with the CFTM Decision?

☐ Yes ☐ No

If anyone disagrees with the CFTM Decision, please provide details:

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

## Signature Page for CFTM

By signing this document you acknowledge that you are a participant of this meeting. Your signature also indicates that you agree as a participant of this meeting to keep all information presented by the other participants of this meeting confidential, including but not limited to, the contents, purpose, or outcome of the meeting with anyone outside of the team. By signing this document you acknowledge that you understand the release of information regarding this case is prohibited by law, except in certain circumstances determined by DCS. If a member of the team is unwilling to sign this document, please print their name on the signature page and note the refusal to sign in the disagreement portion of this document.

[illegible]

This signature is required if the CFTM resulted in a placement move to a Qualified Residential Treatment Program (QRTF). Due to the CANS actionable items and all other reasons discussed in this CFTM, the team is in agreement that this child's/youth's needs cannot be met in a foster home. A QRTF is the most appropriate placement to meet the needs of this child/youth.

**Signature \_\_\_\_\_ (COE Assessment Consultant/Third Party Reviewer)**

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

**Distribution: Case File and Each CFTM Participant**

CS-0747 (Rev. 7/21)

## **GUIDE TO NEEDS AND STRENGTHS**

### **Strength Categories:**

Community Connections  
Education  
Employment  
Family Bond  
Family Safety  
Financial Resources  
Health Insurance  
Home Maintenance  
Independent Living Skills  
Interpersonal Relationships  
Involvement in Caregiver Functions  
Job Functioning  
Knowledge of Child and Family Needs  
Mental Health  
Natural Supports  
Optimism  
Other  
Parental Permanency  
Parenting Skills  
Physical Health  
Preparation for Adulthood  
Relationship  
Residential Stability  
Resiliency  
Social Functioning  
Spiritual/Religious  
Supervision  
Support System  
Talents/Interests  
Transportation  
Vocational

### **IL Strength Categories**

Education  
Employment  
Financial Resources  
Health Insurance  
Home Maintenance  
Independent Living Skills  
Involvement in Caregiver Functions  
Job Functioning  
Knowledge of Child and Family Needs  
Other  
Mental Health  
Parent/Parenting Skills  
Physical Health  
Preparation for Adulthood  
Relationship  
Residential Stability  
Social Functioning  
Social Support  
Transportation  
Vocational

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)

## **GUIDE TO NEEDS AND STRENGTHS**

### **Need Categories:**

Assault	Parenting
Attachment	Permanency
Criminal Activity	Physical Abuse
Danger to Others	Physical Condition of Home
Delinquencies	Physical Health ( <b>also IL</b> )
Developmental Delays	Preparation for Adult Living ( <b>IL</b> )
Discipline	Relationship ( <b>also IL</b> )
Domestic Violence	Residential Stability ( <b>also IL</b> )
Education ( <b>also IL</b> )	Resources
Emotional Abuse	Restorative Justice
Employment ( <b>also IL</b> )	Runaway
Family Conflict	Safety
Family Extended	Self-Mutilation
Family Functioning	Sexual Abuse
Financial Resources ( <b>also IL</b> )	Sexual Aggression
Fire Setting	Sexual Offender
Health Insurance ( <b>also IL</b> )	Sexually Reactive
Home Maintenance ( <b>also IL</b> )	Social Functioning ( <b>also IL</b> )
Immigration ( <b>also IL</b> )	Substance Use/Abuse
Independent Living Skills ( <b>IL</b> )	Suicide Risk
Job Functioning ( <b>also IL</b> )	Support System ( <b>also IL</b> )
Marital Conflict	Transportation ( <b>also IL</b> )
Mental Health ( <b>also IL</b> )	Trauma
Neglect	Vocational ( <b>also IL</b> )
Other Behaviors	
Other Self-Harm	

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0747 (Rev. 7/21)



## Notice of Action

### Special Note to DCS Family Service Workers:

This Notice of Action (NOA) must be completed for each level of care change, higher or lower, for levels 2, 3, or 4 within 2 days of the Child and Family Team Meeting (CFTM)

Date NOA Completed: \_\_\_\_\_

Child's Name: \_\_\_\_\_

TFACTS ID: \_\_\_\_\_

DCS Region: \_\_\_\_\_

County of Custody: \_\_\_\_\_

Date of Custody: \_\_\_\_\_

FSW Name: \_\_\_\_\_

FSW Phone #: \_\_\_\_\_

Date of CFTM: \_\_\_\_\_

**THIS NOTICE TELLS YOU ABOUT THE PLACEMENT DECISION DCS MADE AND WHAT YOU CAN DO IF YOU DISAGREE WITH THE DECISION OR HAVE TO WAIT FOR PLACEMENT.**

**FEDERAL LAW, 42 U.S.C.A. §672(a)(2)(B), and STATE LAW, T.C.A. §37-1-129(c)(1), GIVE DCS THE AUTHORITY TO DECIDE YOUR PLACEMENT BECAUSE YOU ARE IN DCS' LEGAL CUSTODY.**

**WE HAVE LOOKED AT WHAT YOU NEED AND MADE THE FOLLOWING DECISION:**

New, Recommended

Placement and level of

care we think you need: \_\_\_\_\_ Start Date: \_\_\_\_\_

Previous Placement

and Level of Care we

think is no longer

needed: \_\_\_\_\_

This placement will stop on: \_\_\_\_\_

Who made this decision? \_\_\_\_\_

Will there be a wait for the recommended placement? Yes ☐ No ☐ If yes, reason for delay: \_\_\_\_\_

We expect the recommended placement to be provided in: ☐ 1 week ☐ 2 weeks ☐ 30 days

If there will be a delay, you will receive these services until the recommended placement can be made:

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0800 (Rev. 03/17)

What context was this decision made? (i.e. CFTM, legal consult, professional meeting, treatment team meeting, etc).

**How was this new placement decided?** (check all that apply):

- ☐ Completion of Treatment Goals
- ☐ CPS Investigation
- ☐ Court Recommendations
- ☐ Emergency Health Care/Mobile Crisis
- ☐ Well-Being Information and History Form
- ☐ EPSDT Screening
- ☐ PCP Recommendations
- ☐ CFTM
- ☐ Mental Health Assessment (Psychological)
- ☐ DCS Assessments (CANS, etc.)
- ☐ Educational Assessment
- ☐ TEIS Evaluation
- ☐ COE Evaluation
- ☐ Disruption
- ☐ Runaway
- ☐ Hospitalization
- ☐ Administrative Issue at Current Placement
- ☐ Immediate Circumstances Require this Level of Care
- ☐ New Custody Child/Youth
- ☐ Other: \_\_\_\_\_

**Reason for placement change. This is why we made this decision.** (check all that apply):

- ☐ Initial medical/behavioral indicators require this level of care.
- ☐ CFTM recommends this level of care.
- ☐ Current Assessments indicate a higher/lower level of care is needed.
- ☐ Progress in treatment warrants a step down in level of service.
- ☐ Re-evaluation of treatment progress indicates higher level of care needed.
- ☐ Child's behavior requires an immediate change in placement.
- ☐ Completion of incarceration at YDC indicates a change of placement.
- ☐ Administrative circumstances require a change of placement.
- ☐ Judicial review/order received and placement determination made to address service needs.
- ☐ Special investigation requires change of placement.
- ☐ Other: \_\_\_\_\_

**Who did we talk to when making this decision?** (check all that apply):

- ☐ CFTM Members
- ☐ Placement Provider Staff
- ☐ Treating Provider
- ☐ Court
- ☐ PCP
- ☐ School
- ☐ DCS Consultants
- ☐ Foster Care Review Board
- ☐ CASA

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0800 (Rev. 03/17)

- ☐ Child's Current Caregiver  
☐ Child's Former Caregiver  
☐ GAL  
☐ Public Defender/Public Defender Staff  
☐ Other: \_\_\_\_\_

**What documents did we use to help us make this decision?** (check all that apply):

- ☐ DCS Assessments (List: \_\_\_\_\_)  
☐ External Assessments (List: \_\_\_\_\_)  
☐ Discharge Summaries  
☐ Progress Reports  
☐ Court Documents  
☐ School Records  
☐ Other: \_\_\_\_\_

Did anyone at the CFTM say they want to appeal this placement decision? Yes ☐ No ☐

Who said they wanted to appeal? \_\_\_\_\_

**THESE PERSONS GET A COPY OF THE NOTICE OF ACTION**

<b>INCLUDE NAMES, CURRENT ADDRESSES &amp; ENSURE THAT THIS INDIVIDUAL IS ENTERED INTO TFACTS AND THE RELATIONSHIP HAS BEEN ESTABLISHED PRIOR TO GIVING TO PLACEMENT UNIT</b>		Attended CFTM?	Received NOA?	TennCare Appeal Form Given
Youth (14 and over):		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
*Biological Mother:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
*Biological/Putative/Legal Father:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
*Adoptive Mother/Legal Caretaker:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
*Adoptive Father/Legal Caretaker::		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
**Other Involved Adult(s):		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
GAL:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Other Advocate:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
Youth's attorney:		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
		<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0800 (Rev. 03/17)

Foster Parent(s):	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
DCS Contract Agency Provider:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

\* If parental rights terminated, parents do not receive a copy of the NOA.

\*\* At discretion of FSW, based on the person's involvement in making decisions about the child's care.

**What to do if waiting this long is a problem for the child.** You can appeal. Someone else will take a look at this. They can see if there is a way to get the care quicker if the child needs it quicker.

**What to do if you think we are wrong.** You can appeal. Someone else will take a look at what this child needs. You have **30 days** from the date you got this letter to appeal.

**There are three ways to appeal.**

- 1. Mail. An appeal form is attached.** You can mail it or a letter about your problem to the  
**TennCare Solutions Team**  
**P. O. Box 000593**  
**Nashville, TN 37202-0593**
- 2. Fax.** You can fax your appeal form or a letter to **888-345-5575** (toll free) or **741-1338** (Nashville area).
- 3. Call.** You can call the TennCare Solutions Team at **1-800-878-3192** or **253-4479** (Nashville area). Please call during the day if possible, but you can call anytime. If you have an emergency, someone can help you day or night.

If this child needs the care right away, **you may ask for a fast appeal.**

**If this child is already getting care, he or she may be able to keep getting it during the appeal.** To do this, you must appeal **within 10 days** of getting this letter. You must say that you want this child to keep getting the care during the appeal. **If there must be a doctor's order or prescription for the care, this child can keep the care only if there is a doctor's order or prescription.**

**We will be happy to talk about this with you.** You can call your FSW \_\_\_\_\_ to find out more.

**For special help on appeals for children in DCS custody, you may call the TennCare Consumer Advocates, Phone 1-855-283-0007.**

**Need special help because you have a health, learning, or other problem?** Please let us know. There are several places that can help you. When you call the TennCare Solutions Team at **1800-878-3192** tell them about any help that you need. People with hearing or speech problems can use their **TTY/TDD** machine by calling **1-800-772-7647 or 313-9240 (in the Nashville area.)**

**Hay una linea telefonica en Espanol** para los consumidores Hispanos de TennCare. Llame al proyecto en Espanol de TennCare al Tel. **1-800-254-7568.**

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0800 (Rev. 03/17)

**Important Numbers**

**TennCare Solutions Team,**

P. O. Box 000593

Nashville, TN 37202-0593

**PHONE: 1-800-878-3192**

**FAX: 888-845-5575** (toll-free)

**TTY/TDD: 1-800-772-7647**

**ESPAÑOL: 1-800-254-7568**

Sincerely,

Department of Children's Services

*Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.*

Distribution: Case File and Each CFTM Participant

CS-0800 (Rev. 03/17)

# Having problems getting health care or medicine in TennCare?

**Need help filing a medical appeal?**

Call **1-800-878-3192** for free.

## Use this page **only** to file a TennCare Medical Appeal

Fill out **both** pages. These are **facts we must have to work your appeal**. If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192**. If you call, we can also take your **appeal by phone**.

### 1. Who is the person that wants to appeal?

Full name \_\_\_\_\_ Date of birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Or number on their TennCare card \_\_\_\_\_

Current mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

The name of the person we should call if we have questions about this appeal: \_\_\_\_

A daytime phone number for that person \_\_\_\_\_

### 2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name. \_\_\_\_\_

Are you a: ☐ Parent, relative, or friend ☐ Advocate or attorney ☐ Doctor or health care provider

### 3. What is the appeal for? (Place an X beside the right answer below.)

Want to **change health plans**. (Fill out **Part A** on page 2.)

**Need care or medicine**. (Fill out **Part B** on page 2.)

Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

### 4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, if you have an emergency, you may be able to get an expedited appeal. This means your appeal will be decided in 3 business days. An emergency means that if you don't get a decision on your appeal within 3 business days, it could **seriously jeopardize (put in danger)**:

- your life;
- your physical health;
- your mental health; or
- your ability to reach, get back, or keep your mind and body as healthy as possible.

**Do you still think you have an emergency?** If so, you can ask TennCare for an expedited appeal. Your health plan will decide if your appeal should be expedited because you have an emergency. If so, then your appeal will be decided in 3 business days from the date TennCare receives your appeal. But, if your health plan decides that your appeal should **not** be expedited, then you will get a hearing within 90 days.

**Also**, if your doctor thinks you need an expedited appeal, your doctor can go to **tn.gov/tenncare**. Click "Providers," and then click "Miscellaneous Provider Forms" to fill out

a "Provider's Expedited Appeal Certificate". Your doctor should fax the certificate to **1-866-211-7228**. Your health plan will review the certificate and make a decision about your appeal. If your health plan thinks the appeal should be expedited, you will get a decision on your appeal in 3 business days from then. But, if your health plan decides your appeal should **not** be expedited, then you will get a hearing within 90 days from the date you filed your appeal.

TC-0182 (Rev. 01Jan17)  
2578

**Keep reading.** There is **1 more page** for you to fill out.

RDA

**5. Tell us why you want to appeal** this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

---

---

To see which Part(s) you should fill out below, look at number **3** on page 1.

**Part A. Want to change health plans.** Name of health plan you want \_\_\_\_\_

**Part B. Need care or medicine.** What kind - be specific \_\_\_\_\_

- What's the problem?
- ☐ Can't get the care or medicine at all.
  - ☐ Can't get as much of the care or medicine as I need.
  - ☐ The care or medicine is being cut or stopped.
  - ☐ Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? ☐ Yes ☐ No If yes, doctor's name \_\_\_\_\_

Have you asked your health plan for this care or medicine? ☐ Yes ☐ No If yes, when? \_\_\_\_\_

What did they say? \_\_\_\_\_

Did you get a letter about this problem? ☐ Yes ☐ No If yes, the date of the letter \_\_\_\_\_

Who was the letter from? \_\_\_\_\_

**Are you getting this care or medicine from TennCare now?** ☐ Yes ☐ No

Do you want to see if you can keep getting it during your appeal? ☐ Yes ☐ No

Does your doctor say you still need it? ☐ Yes ☐ No If yes, doctor's name \_\_\_\_\_

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

**Part C. Bills for care or medicine you think TennCare should pay for**

The date you got the care or medicine \_\_\_\_\_ Name of doctor, drug store, or other place that gave you the care or medicine \_\_\_\_\_ Their phone number \_\_\_\_\_

Their address \_\_\_\_\_

Did you **pay for the care or medicine and want to be paid back?** ☐ Yes ☐ No

If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.

If you didn't pay, **are you getting a bill?** ☐ Yes ☐ No

If yes, and you think TennCare should pay, you must send a copy of a **bill**. Tell us the date you first got a bill (if you know). \_\_\_\_\_

### **How to file your medical appeal**

Then, **mail** these pages and other facts to:

### **Make a copy of the completed pages** to keep.

TennCare Solutions

**P.O. Box 593**

Nashville, TN 37202-0593

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through. To appeal by **phone**, call 1-800-878-3192 for free.

Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

### **We do not allow unfair treatment in TennCare.**

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability. If you think you've been treated unfairly, call the Tennessee Health Connection for free at **1-855-259-0701**.