

## Notification of Person in Need of Special Assistance

If an individual who has been determined to be SMI is deemed by a qualified assessor to be in need of Special Assistance per the criteria in Arizona Administrative Code Title 9, Chapter 21, section 101(13) and ADHS/DBHS Policy GA 3.4, the identifying person/agency must notify the Office of Human Rights within three (3) days at fax number 602-364-4590. The notification is required regardless of whether someone is providing assistance that meets the individual's Special Assistance needs.

### Part A: Notification

The following person is in need of Special Assistance to assist in effectively participating in the following (check all that apply):

- ISP Process
- ITDP Process                      If currently inpatient, from \_\_\_\_\_  
list inpatient facility
- Grievance Process                      Grievance currently pending:  No  Yes: \_\_\_\_\_  
docket # (if known)
- Appeal Process                      Appeal currently pending:  No  Yes: \_\_\_\_\_  
docket # (if known)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

T/RBHA: \_\_\_\_\_ Provider Site: \_\_\_\_\_  
Case Manager: \_\_\_\_\_ Clinical Liaison: \_\_\_\_\_  
Site Phone: \_\_\_\_\_ Site Fax: \_\_\_\_\_

Please explain the specific circumstances considered in deeming the person in need of Special Assistance and how they affect the person's ability to participate effectively in the ISP, ITDP, grievance/investigation and/or appeal processes:

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Please indicate whether the person's Special Assistance needs are being addressed currently and by whom:  No (see below)  Yes

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_ Address: \_\_\_\_\_

The person is not receiving assistance to meet his/her Special Assistance needs, so he/she is in need of an advocate being assigned for the following needs (check all that apply):

- ISP                       Grievance Process  
 ITDP                       Appeal Process

Is the person in need of Special Assistance aware that you are submitting this notification of Special Assistance?  Yes  No, please explain: \_\_\_\_\_

Date Completed: \_\_\_\_\_ By: \_\_\_\_\_  
Name and Title

Phone Number

Email Address

**PART B: Response from the Office of Human Rights (OHR)**

Re: \_\_\_\_\_ Original Part A Notification Date: \_\_\_\_\_  
List consumer name

Per the information submitted, the person meets necessary criteria for Special Assistance:  
\_\_\_ No, see below for more information.  
\_\_\_ Yes, the person’s Special Assistance needs are (check all that apply):  
\_\_\_ ISP                      \_\_\_ Grievance Process  
\_\_\_ ITDP                     \_\_\_ Appeal Process

The needs are being met by:  
\_\_\_ OHR: Assigned Advocate \_\_\_\_\_, as of \_\_\_\_\_  
\_\_\_ Other: \_\_\_\_\_  
Name and Relationship  
\_\_\_\_\_  
Address and Phone Number

\_\_\_ Not Known (supplemental response will be submitted within 5 business days)

Date returned: \_\_\_\_\_ By: \_\_\_\_\_  
Name and OHR Title

Additional information (if applicable):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Part C: Notification of Change**

*If a qualified assessor determines that the individual no longer needs Special Assistance, this portion should be filled out and submitted to OHR.*

As of \_\_\_\_\_, the above referenced individual no longer meets the criteria to be in need of Special Assistance for the following reasons: \_\_\_\_\_  
\_\_\_\_\_

I have informed the person that I am notifying OHR about the change in circumstances, and that the person no longer meets the criteria for a person in Need of Special Assistance. \_\_\_ Yes \_\_\_ No, please explain: \_\_\_\_\_

Date Completed: \_\_\_\_\_ By: \_\_\_\_\_  
Name and Title