



Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Toll-Free: 1-888-466-2219 | Fax: 916-255-5241
Email: helpline@dmhc.ca.gov
www.dmhc.ca.gov

October 7, 2024

[REDACTED]

Patient: [REDACTED]

Health Plan: Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)

Dear [REDACTED]

Thank you for sending your Independent Medical Review (IMR)/Complaint Form to the Department of Managed Health Care (Department).

You are receiving this letter because we need additional information to process your complaint. The Department recently received additional information to confirm the facility named in your complaint is a secure treatment facility. California law requires certain conditions be met before a minor can be placed into a secure treatment facility. For your complaint to proceed through the IMR process, the Department requires documentation of either of the following:

1. Valid court order appointing the parent(s) or authorized assistant as the conservator for [REDACTED]

OR

2. Documentation from an appropriately licensed mental health provider stating:
 - a. [REDACTED] has a serious mental health or substance use disorder that requires admission to a secure facility;
 - b. The proposed treatment is expected to improve [REDACTED] condition; **and**
 - c. Less restrictive behavioral health services have been attempted.

AND

3. a. A written statement signed by both parents or the parent with sole legal custody consenting to [REDACTED] treatment in a secure facility. A parent with sole legal custody must submit a court order demonstrating they have sole legal custody and control of the minor.

Protecting the Health Care Rights of More Than 29.8 Million Californians
Contact the DMHC Help Center at 1-888-466-2219 or www.dmhc.ca.gov

AND

- b. A statement signed by [REDACTED] and their attorney or patient rights advocate, who is not a family member, showing [REDACTED] made a knowingly and voluntarily waiver of their right to a preadmission administrative hearing after being advised by the attorney or notified by the advocate of their right to a preadmission hearing. If [REDACTED] waives their right to a preadmission hearing after being notified of their preadmission hearing right by a patient advocate, [REDACTED] statement must also state they were told of their right to receive advice from an attorney and they knowingly and voluntarily waived their right to an attorney. An example of a preadmission hearing is a meeting with a judge who listens to why sending [REDACTED] to a secure facility will improve their condition, and the judge decides whether secure treatment is appropriate.

The statement required under 3b. is not required if you provide the findings and court order from a preadmission hearing held pursuant to [Section 4094, subdivision \(i\), of the California Welfare and Institutions Code](#) stating [REDACTED] suffers from a mental disorder; there is a substantial probability that treatment will significantly improve [REDACTED] mental disorder; the proposed placement is the least restrictive setting necessary to achieve the purposes of treatment; and, there is no suitable alternative to a secured treatment placement.

Please submit the requested information along with the Requested Information Sheet (Page 4 of this letter) to the Department within seven days from the date of this letter. Please note you must include the Requested Information Sheet (Page 4) to ensure the information you submit is attached to your case.

The quickest way to return this information to the Department is by replying directly to the email without modifying the Subject line. If that option is not available to you, send it via email to helpline@dmhc.ca.gov or by fax to 916-255-5241. Lastly, the requested information can be mailed to:

**Department of Managed Health Care
Help Center
980 9th Street Suite 500
Sacramento CA 95814**

If you are unable to respond with the requested information within seven days, your complaint will be closed. You may use the enclosed IMR Application/Complaint Form to request that a new case be opened. You may also file an online IMR Application/Complaint Form at www.dmhc.ca.gov.

If you need assistance obtaining the required information, please contact the Health Consumer Alliance (HCA). HCA maintains free telephone and in-person assistance programs to help people navigate their health coverage and problems with their health plans. You can request assistance from HCA either online at <https://healthconsumer.org/> or by calling 888-804-3536.

If you have questions, please call us toll-free at 888-466-2219. You may also go to our website at www.dmhc.ca.gov, which has more information about the Department and consumer health care rights in California.

Sincerely,

Shellie
Senior Attorney
Help Center
Department of Managed Health Care

Attachment(s)



REQUESTED INFORMATION SHEET

- Please complete all sections of the enclosed IMR/Complaint Form.
- Please sign the enclosed IMR/Complaint Form.

Note: An enrollee 18 years of age or older must sign the IMR/Complaint Form unless legal documentation is provided showing that someone else has the authority to act on the enrollee's behalf.

- Please complete the highlighted section(s) of the enclosed Authorized Assistant Form. If we do not receive a completed Authorized Assistant form, we can still process your IMR/Complaint. However, we will only be able to share information about the IMR/Complaint with you.
- Please provide the specific medical treatment(s)/service(s), and/or medication(s) you are requesting. Please see the highlighted section of the enclosed IMR/Complaint Form.
- Please provide a letter signed by your physician/provider certifying that an imminent and serious threat to your health exists and your case should be expedited. Please note that the letter must describe the imminent and serious threat that exists.
- Please complete and return the enclosed Legal Representative for Deceased Patient Form, along with copies of applicable documentation (i.e., death certificate and either a will, trust, or a court order demonstrating you are the legal representative for the deceased patient).
- Please provide the following medical records or documents.

Evidence of conservatorship (Item 1) or documentation a clinician recommended
treatment at the secure facility (Item 2) and evidence the minor received necessary
due process to be admitted to a secure facility (Item 3)

