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2200 GRIEVANCE AND APPEALS

2201 Overview

This chapter sets forth the procedures for proper notice of intended action, informal resolution of complaints, administrative review, grievances, hearings and appeals.

Members with the Division of Developmental Disabilities (the Division) have grievance and appeal rights afforded to them under both the state program and the Arizona Long Term Care System, dependent upon their eligibility and the matter of dissatisfaction.

2202 Definitions

Action: a written decision made by the Division not agreed upon by the member/responsible person, when Arizona Long Term Care System (ALTCS) actions include:

- A. service denial or a limited authorization (an authorization in an amount, duration or scope less than what is ordered or requested) of a requested service, including the type or level of service, is granted; or
- B. a previously authorized service is reduced, suspended or terminated; or
- C. payment for a service, in whole or in part, is denied in accordance with the Arizona Administrative Codes; or
- D. authorization of services not initiated in a timely manner; or
- E. a request by a member, who resides in a rural area with only one health plan, is denied his/her right to obtain services outside the network.

ALTCS Notice of Action: the written notice to the affected member regarding an action by the Division.

Appeal: formal process under Arizona Long Term Care to request a review of an action taken by the Division.

Administrative Decision: the formal decision made by the Office of Compliance and Review (OCR) related to a state funded service, including eligibility

Administrative Review: formal review and investigation of the stated issues conducted by the Office of Compliance and Review (OCR) or assigned designee.

Grievance: a member/responsible person's expression of dissatisfaction with any aspect of a member's care not involving an action.

Notice of Intended Action: a letter from the Division related to a state funded service informing the member/responsible person of the decision and the member/responsible person's due process rights.

Notice of Appeal Resolution: the formal written decision made by the Office of Compliance and Review (OCR) regarding an ALTCS covered service.

2203 Informal Resolution/Grievance Process (Non-ALTCS)

A member/ responsible person may have a grievance or expression of dissatisfaction with any aspect of his/her care such as a quality of care issue or problems related to communication or courtesy. A member or his/her responsible person will be encouraged to discuss any problems with the Support Coordinator as soon as they arise to seek resolution. The Support Coordinator is responsible for reviewing the grievance(s) and attempting to resolve it informally before the grievance is elevated to the Office of Consumer and Family Support.

If necessary, the Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution.

If needed, the DPM or designee may assist in the informal resolution. At any time, the member or his/her responsible person may contact the Support Coordinator's Supervisor or Program Manager.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or his/her responsible person of the process for filing a grievance in person, by telephone or in writing. The Support Coordinator's responsibilities do not extend to preparing the document for the member or the responsible person.

The Support Coordinator must document the member's complaint, the Support Coordinator's attempts to resolve the complaint, and that the member or his/her responsible person was advised of his/her right to file a grievance and the process for doing so. This documentation should be included in the progress notes.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Office of Consumer and Family Support will advise the member or his/her responsible person in writing of the resolution of the grievance no later than ninety (90) calendar days from the receipt of the grievance and will record all results in the Consumer Resolution Tracking System.

2204 Appeal Process for Members Who Receive State Funded Services

When a decision is rendered by the Assistant Director (AD) with which the member or his/her responsible person does not agree, he/she may file a request for a hearing by the DES Office of Appeals. The appeal request must be made in writing and received by OCR no later than 30 calendar days after the postmark date of the decision letter. The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

Once the hearing request is made, OCR staff will prepare a duplicate file for submission to DES along with the hearing request. This file will include copies of the Notice of Intended Action, request for administrative review, investigative materials, and the decision letter.

DES representatives will schedule the hearing and the member/responsible person will be notified of the date and time of the hearing in writing. DES will also notify OCR of the hearing schedule.

At the hearing, the member or his/her responsible person, including any legal representative and a Division representative will meet with a DES Hearing Officer. This hearing is informal and the rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence and the record supplied by OCR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision in writing. Any member adversely affected by the decision will be notified (by the Hearing Officer) of the right to appeal the decision.

An appeal of the Hearing Officer's decision, if requested, must be made to the DES Office of Appeals no later than fifteen (15) calendar days after the date of the decision. The request must completely explain the grounds on which the appeal is being made.

Appeal requests should be sent to:

DES Office of Appeals
1951 West Camelback Road, Suite 360
Phoenix, Arizona 85015

The DES Office of Appeals/Appeals Board (the Board) will decide the appeal. The

Board will issue a final written decision on the matter within a reasonable time period.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the DES decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

2205 Notice of Intended Action (State only)

A Support Coordinator or District representative must issue a written Notice of Intended Action to any member/responsible person who receives services from DES/DDD that is not eligible to receive Arizona Long Term Care System (ALTCS) services, or the service is not an ALTCS covered service.

State only actions include:

- A. Service denial, change, reduction or termination; or
- B. eligibility is denied or terminated.

The notice must be issued on the Division form, *Notice of Intended Action or Service System Discharge*, and include the following information:

- A. the name and address of the responsible person;
- B. the date that the notice is mailed;
- C. the name of the member affected by this action;
- D. the action that is being taken;
- E. the effective date of the action;
- F. the reason for the action;
- G. what the member/responsible person can do if he/she does not agree with the action being taken; and
- H. the signature of the person authorized to make the decision regarding the determinations noted previously.

Every effort must be made to explain the action using vocabulary the member/responsible person will understand. The notice will be written in English and when appropriate and reasonably possible to do so, in the primary language of the recipient. If the recipient cannot understand the notice, the recipient may call the Support Coordinator for assistance with translation.

A.R.S. § 36-563
A.A.C. R6-6-1802

2206 Administrative Review Process (State Only)

If the member or his/her responsible person does not wish to pursue informal resolution of his/her complaint, or the informal resolution process was not successful, a request for administrative review can be made. This request must be made within 35 calendar days of the attempted informal resolution or written notice of intended action. If there was no informal resolution process or written notice, the member or his/her responsible person has 35 calendar days from the date of the initial problem to request an administrative review.

The request should be made either in writing or by telephone to the Office of Compliance and Review. Verbal requests will not be accepted.

Whatever manner of request for a review is used, the following information must be given:

- A. Member's name, date of incident, address, identification number, birth date and health plan, if appropriate.
- B. Responsible person's name, relationship and telephone number.
- C. Support Coordinator's name and telephone number.
- D. Physician's name, if applicable.
- E. Statement of the nature of the complaint and the action requested.

All written requests for Administrative review should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

OCR will complete a review and investigation of the stated issues. OCR staff will submit a request for facts to the District office. Any documentation of the administrative review must be returned to OCR within 5 calendar days.

OCR staff will then contact the member or his/her responsible person, medical providers, service providers and/or District staff to obtain additional information. Relevant policies will be reviewed and Central Office staff will be consulted as necessary. Once the fact finding is complete, a written decision will be rendered to the member or his/her responsible person within thirty (30) calendar days of receipt of the member's administrative review request.

There will be no change in the member's status or the services he/she receives while the administrative review is occurring. An exception may be allowed under certain circumstances (i.e., a member may need additional services and/or care if

necessitated by a change in health status).

A.R.S. § 36-563
A.A.C. R6-6-1803

2207 Fair Hearings and Appeals

Further appeal options depend on whether the member is ALTCS eligible or whether he/she receives state funded services. There are common components to the two appeal processes, which include:

- A. The hearing must be held at the established hearing location that is most convenient for the member or responsible person. The member and his/her responsible person must be informed of the date, time, and location of the hearing no less than 20 calendar days in advance for standard requests. At the discretion of the hearing officer, the hearing can be conducted by telephone.
- B. The hearing notice must state that the member or responsible person has the right to:
 - i. present his/her case in person or by telephone;
 - ii. receive a copy of all case file documents, and any material that the Division will use in the hearing at a reasonable time before the hearing;
 - iii. obtain assistance from the Division local office in preparing his/her case;
 - iv. make inquiry at the Division local office concerning the availability of free legal resources; and
 - v. request a change of the hearing officer.
- C. Hearings must be conducted in an orderly manner by the hearing officer. The hearing officer can rule on the admissibility of evidence, and include or exclude witnesses. Parties may present evidence, cross examine witnesses and present arguments.
- D. A complete record is made of all hearings. The member and his/her responsible person may inspect the record at a location that is accessible to them.
- E. The hearing decision must be based solely on the evidence and testimony presented at the hearing, appropriate state and federal law, and applicable DES rules.

2208 ALTCS Grievance Process

State Only

A member or his/her responsible person may have a complaint regarding an issue unrelated to a Notice of Intended Action, such as a quality of care issue or problems related to communication or courtesy. Members and their responsible persons will be encouraged to discuss any problems or complaints with the Support Coordinator as soon as they arise. The Support Coordinator is responsible for reviewing and investigating complaints and attempting to resolve them informally before they reach the grievance stage. The Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution. If needed, the DPM or designee may assist in the informal resolution.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or his/her responsible person of the process for filing a grievance in person, by telephone or in writing. The Support Coordinator's responsibilities do not extend to preparing the document for the member or the responsible person.

ALTCS Members

The Support Coordinator must document the member's complaint, the Support Coordinator's attempts to resolve the complaint and the fact that the member or his/her responsible person was advised of his/her right to file a grievance and the process for doing so. This documentation should be included in the case notes.

The Division will acknowledge receipt of a grievance orally or in writing. Receipt of grievances will be recorded in the Consumer Resolution Tracking System.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will provide written or oral notice of the grievance decision within 90 calendar days after the Division receives the grievance and will record all results in the Consumer Resolution Tracking System.

2209 ALTCS Notice of Action

Reasons for Use

A Support Coordinator/designee or health plan representative must issue a written Notice of Action to any member/responsible person or authorized legal representative who receives services from the Division when the member or responsible person is not in agreement to an action that results in a requested service not being authorized in the amount, duration or scope which was ordered/requested.

Standard Request

A Support Coordinator/designee or health plan representative will issue a written Notice of Action within 14 calendar days of the request for authorization of a service for a standard request to reduce, suspend, or terminate an authorized service.

Expedited Request

The Division will expedite a request if it is determined that taking the time for a standard request could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. In these circumstances, the decision must be made within 3 working days from the date of receipt of a service request, with a possible extension of up to an additional 14 calendar days if the criteria for an extension are met.

A Notice of Action will be issued within 3 working days for denial of a service request in which an expedited decision was requested. If a service requested is denied after a Notice of Extension was issued, a Notice of Action will be issued.

If a service request does not seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the expedited request may be downgraded to a standard request. When an expedited request is denied, the Division will promptly contact the member/responsible person orally to advise him/her of the denial to expedite the request. The Division will follow the oral notification with written notice of denial no later than 2 calendar days to the member/responsible person. If the member/responsible person disagree, he/she is allowed to submit additional documentation to support the expedited request.

Notice of Extension

A Notice of Extension may be issued for up to 14 additional days if the Division requires further information to make a decision and it is in the member's best interest. When additional information is not received within the timeframes allowed, the service request will be denied.

Format

The notice must be issued on Division or health plan letterhead, written in an easily understood manner, and available in alternate formats. The notice must include the following information:

- A. the name and address of the responsible person;
- B. the date that the notice is mailed;
- C. the name of the member affected by this action;

- D. the action that has been taken or intends to be taken;
- E. the effective date of the action. A Notice for a previously authorized service must be sent at least 10 days before the date of the proposed termination, suspension, or reduction;
- F. the reason for the action;
- G. what the member/ responsible person can do if he/she does not agree with this action;
- H. how to request an expedited resolution of the appeal;
- I. the circumstances under which services can be continued pending resolution of the appeal; and,
- J. the signature of the person authorized to make the decision regarding the determinations noted previously.

2210 ALTCS Appeal Process

Filing an Appeal

When a Notice of Action is given by the Division or health plan representative with whom the member/responsible person does not agree, he/she may file an appeal. An authorized representative, including a service provider, may file an appeal on the member's behalf, with written consent from the member/responsible person. The Division will not take punitive action against a service provider who requests a resolution of the appeal or who supports the member's request for a resolution of the appeal.

The member/responsible person/authorized representative must file the appeal either orally or in writing with the Office of Compliance and Review (OCR) within 60 calendar days after the date of the Notice of Action. OCR will acknowledge receipt of the appeal in writing within 5 calendar days.

The Division will assist the member/responsible person with the completion of forms and other procedural steps, upon request. The member/responsible person/authorized representative may present information to the Division at any time during the appeal process. The member/responsible person may review the member's records and other documents considered before and during the appeal process, not protected from disclosure by law.

Appeal Resolution Timeframe

The Division will respond to the standard appeal and mail the written Notice of Appeal Resolution to the member/responsible person/authorized representative within thirty (30) calendar days after the date the Division receives the appeal. The Division will extend the 30-day time frame up to an additional 14 calendar days

upon request by the member/responsible person. The Division may request a 14 calendar day extension of the 30-day time-frame if additional information is needed and the extension is in the best interest of the member. The Office of Compliance and Review (OCR) will provide the member/ responsible person written notice of the reason for the decision to extend the 30-day time frame.

Expedited Appeals

The member/responsible person/authorized representative may request an expedited resolution of the appeal. The Division will conduct an expedited appeal if it is determined that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Division will conduct an expedited appeal if a request is received directly from a health care provider, with written authorization from the member/responsible person, and the health care provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

If the request for an expedited appeal is denied, OCR will promptly contact the member/responsible person orally to advise him/her of the denial. OCR will send written notice of the denial no later than 2 calendar days to the member/responsible person. If a request for an expedited appeal is denied, the Division will resolve the appeal no later than 30 calendar days after the day the Division receives the appeal.

If the request for an expedited appeal is granted, the Division will adjudicate the appeal and mail the written Notice of Appeal Resolution to the member/responsible person/authorized representative within 3 working days after the day the Division receives the request for an expedited appeal. The Division will extend the 3-day time frame up to an additional 14 calendar days upon request by the member/responsible person. The Division may request a 14 calendar day extension of the 3-day time frame if additional information is needed and the extension is in the best interest of the member. OCR will provide the member/responsible person written notice of the reason for the decision to extend the 3-day time frame.

Appeal Decisions and Timeframes

The Division will ensure that the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will render a written Notice of Appeal Resolution to the member/responsible person no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the

resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or 3 working days for an expedited, the member may consider the appeal denied.

If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

- A. the member's right to request a fair hearing and how to do so;
- B. in cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;
- C. the factual and legal basis of the decision; and
- D. the member/responsible person's liability for the cost of the continued services if AHCCCS upholds the DES/DDD decision.

A.A.C. R9-34-209 through
A.A.C. R9-34-216

2211 ALTCS Fair Hearing Process

When a Notice of Appeal Resolution is rendered by the Division with which the member or his/her responsible person does not agree, he/she may file a request for a fair hearing by the Office of Administrative Hearings (OAH). The fair hearing request must be filed in writing and received by OCR no later than thirty (30) calendar days after receipt of the Notice of Appeal Resolution.

The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

Once the hearing request is filed, OCR staff will prepare a duplicate file for submission to the Arizona Health Care Cost Containment System (AHCCCS) along with the hearing request. The OCR staff will submit the file to AHCCCS within five (5) days. This file will include copies of the Notice of Action, request for fair hearing, investigative materials and the decision letter.

The hearing will be scheduled by AHCCCS and the member or his/her responsible person will be notified of the date and time of the hearing in writing. The member and/or responsible person including any legal representative, an Assistant Attorney General, and a Division representative will meet with an Administrative Law Judge (ALJ). This hearing is formal and the rules of evidence may not apply.

Based on the information gathered by the ALJ through testimony, presentation of evidence and the record supplied by OCR, the ALJ will prepare written findings of fact and conclusions of law, and render a recommended decision to the AHCCCS Director. The AHCCCS Director will then issue his/her decision in writing and notify any party adversely affected of the right to request a rehearing or review. If it is decided that a review will not be petitioned, the OCR will arrange with the appropriate Division staff and /or contracted health plan staff to authorize and provide the service as expeditiously as possible.

A petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services (OALS) no later than thirty (30) calendar days after the date of the AHCCCS Director's decision. The petition must completely explain the grounds on which the rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The rehearing will be decided by the AHCCCS Director or designee and a final written decision on the matter will be issued.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

2212 Claim Disputes

Claim Dispute Process

A Division representative or health plan representative will provide written notice advising the service provider of a denial of claim payment and the reason for denial. The notice may be included in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the Division or a Division subcontracted health plan.

When a notice is given by the Division or a Division subcontracted health plan with which the service provider does not agree, the service provider may file a claim dispute. A claim dispute will be accepted by the Division or the Division subcontracted health plan only if the dispute involves a payment of a claim, denial of a claim, an imposition of a sanction or reinsurance.

The service provider must file the claim dispute in writing with either the Division or

the Division subcontracted health plan. The claim dispute must be filed within 12 months after the date(s) of service, within 12 months after the date that the member's eligibility is posted or within 60 days after the date of the denial of a timely claim submission.

If the service provider submits the claim dispute directly to the Division subcontracted health plan, the Division subcontracted health plan will forward a copy of the claim dispute to the Division upon receipt. The Division or the Division subcontracted health plan will send the service provider a written notice acknowledging receipt of the claim dispute within 5 working days from the date the claim dispute is received. The Division or Division subcontracted health plan will advise the service provider that any additional information the service provider wishes to submit to the Division for consideration must be done so in 10 calendar days.

OCR staff may contact the service provider and the Division subcontracted health plan to obtain additional information. Subcontracted health plans are required to provide all information related to their recommendation to deny or approve the claim dispute to OCR no later than 10 days after the subcontracted health plan receives the claim dispute. Relevant policies will be reviewed and Central Office staff will be consulted as necessary.

Once the fact-finding is complete, a written Notice of Decision will be rendered to the service provider within thirty (30) calendar days of receipt of the services provider's claim dispute unless the provider and the contractor agree to a longer period. The Notice of Decision will include:

- A. the date of the decision;
- B. the factual and legal basis for the decision; and
- C. the service provider's right to request a fair hearing and how to do so.

A.R.S. §36-2903.01.8.4

A.R.S. §41.1 092

A.A.C R9-34-402 through A.A.C. R9-34-405

State Fair Hearings for Claim Disputes

When a service provider does not agree with a Notice of Decision by the Division on a claim dispute, the service provider may file a request for a fair hearing by the Department of Economic Security (DES) Appellate Services Administration/Long Term Care Services. The request for fair hearing must be made in writing and received by the OCR no later than thirty (30) calendar days after receipt of the Notice of Decision. The request should be sent to:

DES/DDD
Office of Compliance and Review

3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

Once the hearing request is made, OCR staff will prepare a duplicate file along with the hearing request for submission to the DES Appellate Services Administration/Long Term Care and the Attorney General's Office. This file will include copies of the claim dispute, investigative materials and the Notice of Decision.

The hearing will be scheduled by a DES Appellate Services Administration/Long Term Care representative, and the service provider will receive written notification of the date and time. The DES Appellate Services Administration/Long Term Care representative will also notify the Attorney General's Office and OCR of the scheduled hearing.

At the hearing, the service provider, a DES/DDD representative, and an Assistant Attorney General will meet with a DES Appellate Services Administration/Long Term Care Hearing Officer. The rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence and other records supplied by OCR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision. The DES Appellate Services Administration/Long Term Care representative will forward a copy of the decision to the AHCCCS Office of Administrative Legal Services, the service provider, DES/DDD and the Attorney General's Office.

Petition for rehearing or review, if requested must be made to the AHCCCS Office of Administrative Legal Services no later than 30 calendar days after the date of the DES Appellate Services Administration/Long Term Care Administrative Law Judge. The petition must completely explain the grounds on which rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the Division decision, the Division will confer with the Attorney General's Office to determine if a request for review will be petitioned to the AHCCCS Director. If it is decided that a review will not be petitioned, the OCR will arrange with the appropriate DES/DDD staff and/or contracted health plan staff to authorize and make payment for the services as expeditiously as possible.

If the service provider is still not satisfied with the decision, the service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

Overtured or Reversed Claim Disputes

The Division or its Subcontractors shall reprocess and pay overturned or reversed claim disputes, within 15 business days of the date of the Decision. The Division or its Subcontractors will make payments in a manner consistent with the Decision.

2213 Contact with Attorneys or Their Staff

The member/responsible person have a right to have anyone present they wish including an attorney or his/her staff and may tape record a meeting. The Division may have their staff present at a meeting and may tape record a meeting.

2214 Conducting All Meetings

To provide defined objectives and to allow for adequate meeting facilities complete the following:

- A. clarify the purpose of the meeting;
- B. check with the member/responsible person as to how many people they will have in attendance so adequate space will be provided and clarify with the family the names and titles of those attending from the Division; and
- C. schedule space appropriate for the number of people in attendance.

Tape Recording Meetings

Unless there are either pending grievances or legal actions, there is no prohibition for members/responsible persons to tape record Individual Support Plan (ISP) meetings. Canceling a meeting for this reason is not acceptable.

Requests for Member Information

In order to ensure uniformity and conformity, all requests for member information must be cleared through the OCR. Situations include, but are not limited to:

- A. any circumstance where staff may deem it necessary to initiate contact with an attorney or his/her staff; or

- B. any request for member records or communication regarding a member's services unless prior authorized by the OCR.