G. MEMBER RIGHTS

Consumer Grievances, Appeals, and State Fair Hearings

The County of San Diego is committed to providing a fair, impartial, and effective process for resolving client grievances in compliance with all Federal and State regulations for substance use disorder services. The Grievance/Appeals and State Fair Hearing processes are available for all clients, their authorized representative, or providers acting on behalf of the client and with the client's written consent ("involved parties") to utilize. All SUD treatment providers must also have policies and procedures in place for collecting/logging, reviewing, and acting upon all client grievances or appeals. The process should be clear and transparent to all clients and providers and should be integrated into the provider's quality assurance processes. At all times, grievance and appeal information must be readily available for clients without the need for request. (42 CFR §438.228)

The Grievance/Appeals and State Fair Hearing process is designed to:

- Provide grievance/appeals and State Fair Hearing process adhering to Federal and State regulations
- Provide straightforward client/provider access
- Support and honor the rights of every client
- Be action-oriented
- Provide resolution within State established timeframes
- Encourage effective grievance resolution at program level
- Improve the quality of SUD services for all County of San Diego residents

Providers shall have self-addressed stamped envelopes (CCHEA and JFS will provide upon request), posters, brochures, grievance/appeal forms (available on the Optum website) in all threshold languages to include interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. These materials shall be displayed in a prominent public place. The client shall not be discouraged, hindered, or otherwise interfered with when seeking or attempting to file a grievance/appeal. The client is also not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested. Providers shall inform clients, their authorized representative, or the provider acting on behalf of the client, about their right to file a grievance with assistance from one of the County's contracted advocacy organizations listed below (42 CFR §438.406):

Jewish Family Services, Patient Advocacy Program (JFS)
(For inpatient or residential SUD services)
1-800-479-2233 or 619-282-1134
Email:patientadvocacy@jfssd.orgpatientadvocacy@jfssd.org

Website: www.jfssd.org/patientadvocacy

Consumer Center for Health, Education, and Advocacy (CCHEA)
(For outpatient SUD services)
1-877-734-3258
TTY-1-800-735-2929

Advocacy Services and Records Requests
In accordance with the Code of Federal Regulation (CFR) Title 42, Part 438, Subpart F – Grievance System, the JFS Patient Advocacy Program and CCHEA are required to conduct grievance investigations and appeals pursuant to State and Federal law. These processes may include, but are not limited to, consulting

with facility administrators, interviewing staff members, requesting copies of medical records, submitting medical records to independent clinical consultants for review of clinical issues, conducting staff member trainings, suggesting policy changes, submitting requests for Plans of Correction (POC), and preparing resolution letters.

There are mandated timelines for grievances and appeals. Providers' quick and efficient cooperation will ensure compliance with these requirements. When requested, SUD providers shall provide copies of medical records to the JFS Patient Advocacy Program and CCHEA within 3 business days from the date of the medical record request. The Advocacy Agencies will provide the program with a signed release of information from the client with the request. For more information, please review the following memo on the Optum DMC-ODS page: Patient Advocacy Services for BHS

Process Definitions (Title 42 CFR § 438.400 (b))

- **Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination as defined below (under appeal). Grievances may include but are not limited to: the quality of care of services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, failure to respect the rights of the client regardless of whether remedial action is requested, including the client's right to dispute an extension of time proposed by the plan to make an authorization decision. A grievance can be filed at any time, orally or in writing. **(42 CFR § 438.402)**

- **Discrimination Grievance** is when a client believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance (Discrimination grievance" means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation)with the county plan, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights. San Diego County complies with all State and Federal civil rights laws. **(45 CFR §§ 92.7 and 92.8; WIC§14029.91)**

- **Grievance Exemption** is when grievances are received over the telephone or in-person by the County, or a DMC-certified provider, that is resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter. Note: Grievances received via mail are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a complaint is received pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance, and the exemption does not apply.

- **Appeal per federal guidelines, an "Appeal" is a review of an Adverse Benefit Determination** which may include:
    - Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    - The reduction, suspension, or termination of a previously authorized service.
    - The denial, in whole or in part, of payment for a service.
    - The failure to act within the timeframes regarding the standard resolution of grievances

and appeals.
  - The failure to provide services in a timely manner.
  - The denial of a client's request to dispute financial liability.

- **Grievance and appeal system** are the processes the county and providers implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

- **State Fair Hearing** is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal member is required to exhaust the SUD problem resolution process prior to requesting a State Fair Hearing and only a Medi-Cal member may request a state fair hearing.

- **Aid Paid Pending (APP)** Clients have the right to request APP pending their determination. APP indicates that the client's benefits shall continue pending resolution of the appeal and or state fair hearing (42 CFR § 438.420)

In many cases, a responsible and reasonable resolution can be achieved through an informal and professional discussion between the client and the provider, either verbally or in writing. However, additional action in the form of a grievance or appeal may be necessary to offer the client, or if requested by the client. In accordance with 42 CFR and Title 9, the County of San Diego SUD Quality Assurance (QA) team has implemented a SUD Provider Grievance/Appeals and State Fair Hearing process for when client grievances cannot be resolved informally. Timelines for acknowledgement of receipt of grievances/appeals and resolution, are highlighted within the tables below. An opportunity for provider appeals has been added in addition to clinical review of grievances and appeals concerning clinical issues.

Provider Program Grievance Process
Per DHCS requirements, the County must have a process in place to ensure all SUD program clients' grievances are reported and investigated per regulations.

Program and clients are encouraged to resolve grievances at a program level. (Note: Grievances received over the telephone or in-person by a program that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter.) Additionally, programs should refer the client to the appropriate advocacy program for further assistance in finding a resolution to their grievance. If resolution to the client's satisfaction has not occurred by close of the next business day following receipt of a verbal, written, or phone contact grievance, and/or the client refuses to utilize the advocacy organization, programs must notify County SUD QA within 72-hours of receipt of the grievance. Unresolved client grievances should be reported to the program's COR. They are also to be recorded on a SUD Complaint/Grievance Report Form and sent to BHS SUD QA within 72-hours (see Optum site for the SUD Complaint Form) of receipt of the grievance. Completion of this form is to be done by the program with or without the client present.

Programs are required to have policies and procedures in place to address and track all client grievances. Tracking shall include, at a minimum:

- Client initials,
- Date of the grievance,
- Who received grievance,
- How the grievance was made (verbally, in writing, etc.),

- The nature of the grievance,
- How the program responded to the grievance,
- If the grievance was resolved to the client's satisfaction by the close of the next business day following receipt, and if unresolved,
- If client was provided information for the appropriate advocacy agency.

Review of Grievance policies and procedures as well as tracking logs will be part of annual site visits by BHS COR and/or BHS SUD QA.

County of San Diego SUD QA or the appropriate advocacy program shall acknowledge all client grievances, in writing, to the client, within five calendar days. BHS SUD QA will record all SUD Complaint/Grievance Report Forms received and monitor adherence to process regulations internally or through collaboration with the appropriate advocacy agency until client/program resolution occurs. The BHS SUD QA will submit a report to DHCS within two business days from completion of the grievance investigation with outcome. Should a client initiate a grievance directly to BHS, the client will be reminded about their right to file a grievance with assistance from one of the County's contracted advocacy organizations (e.g., JFS or CCHEA). If the client refuses to utilize the advocacy organization, then the SUD QA unit will send the member acknowledgement of receipt of the grievance as described above and contact both the provider and the provider's COR to initiate an investigation and facilitate a resolution within process timeframes as described below.

Grievance Process and Timeframes
A grievance can be filed at any time. A resolution must occur within 30 days (but many will be resolved sooner) from receipt of grievance to resolution. A grievance is defined as an expression of dissatisfaction about any matter other than an "adverse benefit determination." JFS Patient Advocacy facilitates all grievance process for clients within inpatient facilities and 24-hour residential facilities. CCHEA facilitates the grievance process for clients seeking/receiving services within outpatient programs and all other SUD services. Advocacy services will provide the client written acknowledgement of receipt of a grievance within five days of receipt of the grievance. Providers will be contacted within two business days of written permission from the client to represent him/her. To maintain compliance within mandated federal timelines, providers shall work closely with the advocacy organization to find a mutually agreeable solution for grievance resolution. Should a grievance or appeal focus on a clinical issue, then CCHEA and the JFS Patient Advocacy Program will utilize a clinician with the appropriate clinical credentials and treatment expertise to review and render a decision regarding the case.

Grievance tracking logs from JFS and CCHEA are sent monthly to the County SUD QA unit and include at minimum:

- Date of receipt of the grievance
- Client name/identifying number
- Nature of the grievance
- Resolution
- Name of representative who received and resolved the grievance

County of San Diego SUD QA will maintain, review, and provide ongoing monitoring of all logged grievances as protocol for its continual quality assurance and management process.

Description	Receipt of Notification	Written Decision Notification
Grievance An informal/formal expression of dissatisfaction about any matter other than an "action," or adverse benefit determination, quality of care, services, and/or treatment.	Postmarked within five (5) calendar days from receipt of a grievance.	Within 30 calendar days of receipt of a grievance.
Standard Appeal Appeals are a formal process of challenging denial decisions involving, but not limited to DMC eligibility, services, or level of care decisions. *Must be filed within 60 calendar days from the date on the written decision notification/Notice of Adverse Benefits Determination (NOABD)	Postmarked within five (5) calendar days of appeal by advocacy organization.	Within 30 calendar days of receipt of an appeal. Adverse determinations must include information to client re: fair hearing, how to file, right to request and receive benefits, costs, etc. (as specified in DHCS Information Notice 18-010E).
Expedited Appeal The expedited resolution of appeals begins when it is determined (in response to a request from the patient or patient representative), or the provider indicates (in making the request on the patient's behalf), that taking the time for a standard resolution could seriously jeopardize the patient's life, health, or functional status. Appeals for initial residential authorizations and medication-assisted treatment will routinely be expedited. *If request for expedited resolution of an appeal is denied, it will be transferred to the timeframe for standard resolution. Written notification of this change to a standard appeal process will be provided within 72 hours.		Within 72 hours of receipt of an expedited appeal, it must be resolved and notice provided to the client.

Appeal Process
Timeline:

- Filing: Within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NOABD).
- Decision: Within 30 calendar days from receipt of appeal.

Oral and/or written appeals are reviews of actions by the county regarding provision of services through an authorization process, including:

- Reduction/limitation or delay of services
- Reduction, suspension or termination of a previously authorized service
- Denial of, in whole or part, payment for services
- Failure to provide services in a timely manner
- Grievance, appeal or expedited appeal was not resolved in time

Advocacy services will provide the member written acknowledgement of receipt of an appeal postmarked within (5) calendar days of receipt of the appeal. The advocacy organization will contact the provider within two (2) business days of receiving written permission from the client to represent him/her. The advocacy organization shall investigate the appealed matter and make a recommendation to the county. The County will review the recommendations of the advocacy organization and make a decision on the appealed matter.

Note: A decision by a counselor to limit, reduce, or terminate a client's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

Expedited Appeal Process
Timeline: Decision: Decision: Within 72 hours.
Should a standard appeal process jeopardize a client's life, health, or functioning, an expedited appeal may be filed by the advocacy organization on behalf of the client. Notification to the provider by the advocacy organization will occur in less than (2) business days. A decision by the County with notification to affected parties will occur within (72) hours after receipt of the expedited appeal request.

Activity	Timeline		Reference/Notes
What is the timeline for submission of an Appeal?	Within 60 days of Notification of Action-Denial (date on letter). Orally or in writing.		**42 CFR §438.402(c)(2)(ii)**
Timeline for notification of receipt of appeal [Acknowledgement Letter from JFS (residential or inpatient program clients) or CCHEA (outpatient program clients).]	Standard	(5) business days	Can be earlier
	Expedited	If the county plan decides the appeal does not qualify as an expedited appeal, notification is (2) business days.	

Timeline for submission of State Fair Hearing Appeal	Within 120 days after Denial of Appeal	Plan must notify members of resolution within (90) days of date of the request for the hearing. For expedited State Fair Hearings, the Plan must notify members of resolution within (3) working days of the date of the request for the hearing. (**42 CFR§431.244(f)(2)**).

Note: County of San Diego SUD QA will maintain, review, and provide ongoing monitoring of all logged standard and expedited appeals as part of its continual quality review process.

State Fair Hearings (42 CFR §438.402(c))

Medi-Cal members must exhaust the County's appeal process prior to request for a State Fair Hearing. A member has the right to request a State Fair Hearing only after receipt of notice that the County is upholding an Adverse Benefit Determination. Members may request a State Fair Hearing within 120 calendar days from the date of the NAR (Notice of Appeal Resolution).

A request for a State Fair Hearing may occur if:

- Appeals are not wholly resolved
- If a provider/contractor fails to adhere to the notice and timing requirements per **42CFR§438.408**
- After exhausting the grievance process regardless of receipt of a Notice of Adverse Benefit Determination
- Denial of services due to not meeting medical necessity criteria
- Services are not provided in a timely manner
- County denial of provider request for member treatment

County of San Diego SUD QA will maintain, review, and provide ongoing monitoring of all logged State Fair Hearing requests as part of its continual quality review process.

Written requests for a State Fair Hearing:

State Hearing Divisions, California Dept. of Social Services
P.O. Box 944243, Mail Station 9-17-37
Sacramento, California 94244-2430
1-800-952-5253
TDD 1-800-952-8349

State Fair Hearings (42 CFR §438.420) [also known as Aid Paid Pending]

The beneficiary's right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten days from the date the letter was post-marked or delivered to the beneficiary) in accordance with Title 42, CFR, Section 438.420.

Provider Appeal Process

If a provider and advocacy organization cannot successfully resolve a client's grievance or appeal, the advocacy organization will issue a finding to be sent to the client, provider, and County, which may include the need for a Plan of Correction to be submitted by the provider to the County within 10 days. In the rare occurrence when the provider disagrees with the disposition of the grievance/appeal and/or does not agree

to write a Plan of Correction, the provider may write to the County within 10 days, requesting an administrative review. The County shall have the final decision about needed action.

Monitoring the Member and Client Problem Resolution Process

The County shares concern with providers regarding areas affecting improvement in client access to services and improved quality of care in all services provided. County SUD QA staff will monitor and review program and advocacy organization grievance/appeal/state fair hearing logs/records and view feedback from the grievance and appeal process as a reflection of potential problems with service effectiveness and/or efficiency, and as an opportunity for positive change. Depending on the nature of the grievance, more targeted follow up at the provider level may be needed, including concerns inherent in-service access and delivery which may become part of the ongoing contract monitoring and/or credentialing process. The method of feedback, review, and quality review monitoring can more efficiently address needed improvements in system access, delivery, and quality of service for all clients.

Client Notice of Adverse Benefit Determination (NOABD)

An Adverse Benefit Determination is defined as one which encompasses all previous elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness and setting of covered benefits, and financial liability. An Adverse Benefit Determination is defined to mean any of the following actions taken by a provider or the County:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The failure to act within the required timeframes for standard resolution of grievances and appeals
- The denial of a member's request to dispute financial liability.

Members must receive a written NOABD when the Program/Plan takes any of the actions described above. The Program/Plan must give members timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in **42 CFR §438.10.**

All SUD providers shall follow procedures for issuing a written NOABD and "Your Rights" Form for Medi-Cal members per **42 CFR §438.10** to include notification timeframes per **42 CFR §438.404(c).** A NOABD must explain the following:

- The adverse benefit determination made, or the Plan intends to make
- Clear and concise explanation of the reason for the decision
- A description of the criteria used; medical necessity criteria, processes, strategies, or evidentiary standards used
- The members right to be provided upon request, and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the NOABD
- The members right to request a second opinion and/or appeal of the adverse benefit determination and/or right to a State Fair Hearing once the process is exhausted, to include assistance through the process
- Procedures/methods by which the member/provider can exercise appeal rights
- Circumstances under which an appeal process can be expedited/how to request it

- Members right to have benefits continue pending resolution of the appeal
- To request such, and under what circumstances the member may be required to pay the costs of these services.

Issuing of an NOABD begins the 120-day period that a member has to file for a State Fair Hearing.

Provider Process When Issuing a NOABD
The following procedures shall be followed by providers when issuing a NOABD:

- A NOABD and "Your Rights" form shall be issued to a Medi-Cal member following a SUD assessment when it is determined by the provider that the member does not meet medical necessity criteria, resulting in a denial of services
- The appropriate NOABD shall be offered to the member with explanation per regulations with "Your Rights" form
- In accordance with Federal regulations, the NOABD shall be hand delivered on the date of the notice or deposited with the US Postal Service in time for pick-up no later than (2) business days of the decision by the provider

County of San Diego SUD programs shall have a written policy and procedure addressing the collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations. It is recommended that programs maintain all Notice of Adverse Benefit Determinations in a confidential location at the program site for no less than ten (10) years after discharge for adults. For minors, records are to be kept until they have reached the age of 18, plus seven (7) years.

- All SUD programs shall maintain a monthly NOABD Logs on program site
- Programs shall include in their NOABD Logs:
    - Date NOABD was issued
    - Member identification number
    - Member response, requests, provisions for second opinions, initiation of grievance/appeal procedure, and/or request for a State Fair Hearing if known
- NOABD Logs will be maintained at program site
- Logs to contain copies of each NOABD and "Your Rights" forms attached
- Log to reflect "NO NOABD ISSUED" if none are issued within a month
- Program's NOABD Log will be used by the program as a reference to accurately complete the Monthly or Quarterly Status Report (MSR or QSR).
- NOABD Logs must be available for review at COR or SUD QA request.

Types of Notice of Adverse Benefit Determination (NOABD) and Notice of Appeal Resolution (NAR)
NOTE: There are some cases in which a Notice of Adverse Benefit Determination may not be received; in which case, the member/provider can still file an appeal with the county plan. You can request a State Fair Hearing when this occurs.

- Notice of Adverse Benefit Determination – Denial of authorization for requested services
- Notice of Adverse Benefit Determination – Denial of payment for a service rendered by a provider
- Notice of Adverse Benefit Determination – Modification of requested services
- Notice of Adverse Benefit Determination – Termination of a previously authorized service
- Notice of Adverse Benefit Determination – Delay in processing authorization of services
- Notice of Adverse Benefit Determination – Failure to provide timely access to services

- Notice of Adverse Benefit Determination – Dispute of financial liability
- Notice of Appeal Resolution (NAR) – Formal letter informing a member that an Adverse Benefit Determination has been overturned or upheld.

NOABD Table of Notices, Forms, "Your Rights" form, and NAR forms, are available for view/use on the Optum Website under the NOABD tab. You can also access the NOABD Webinar under the NOABD tab.

Transgender, Gender Diverse or Intersex Grievance Monitoring

• Per BHIN 25-019 if a member submits a grievance against a BHP, its subcontractors, or staff for failure to provide trans-inclusive health care, the BHP is required to submit quarterly reports to DHCS.

• BHPs are also required to submit additional information when the outcomes of the grievance reported are resolved in a member's favor. If the grievance is resolved in the member's favor, then the individual named in that grievance must complete a refresher course by retaking the trans-inclusive health cultural competency training (outlined within BHIN 25-019) within 45 days of the resolution of the grievance and before they have direct contact with members again.

• BHPs are required to submit to DHCS verification of the completed refresher training quarterly as well as a reporting template to be submitted within quarterly submission timelines outlined in the BHIN.

Client Rights

Programs shall inform clients of their nine (9) personal rights at an AOD certified program; this is documented in the client file as a signed acknowledgement that the client understands their rights during treatment. In addition to these rights, if the client is a Medi-Cal member, the client is entitled to additional rights. Clients are to review these additional rights in the Drug Medi-Cal Organized Delivery System Member Handbook offered to the client at the time of admission to the program. They will also sign a form acknowledging they were offered the Member Handbook.

Client's Personal Rights, Complaint Information, and Advance Directive, for AOD Certified/Licensed Programs forms, are available for view on the OPTUM website see 203b_Client Rights under the SUDURM tab, and all brochures can be found under the Beneficiary tab.

AB 1740 Requirements to Post Human Trafficking Notice

AB 1740 amends Section 52.6 of the Civil Code relating to human trafficking to additionally require a notice, as developed by the Department of Justice, that contains information relating to slavery and human trafficking, including information regarding specified nonprofit organizations that a person can call for services or support in the elimination of slavery and human trafficking be posted by facilities that provide pediatric care, as defined in W&I Code Section 16907.5

- "Pediatric services" means all medical services rendered by any licensed physician to persons from birth to 21 years of age.
- The notice must be posted in English, Spanish, and third language that is most widely spoken in the county (notice template is available on the California's DOJ's website Notice Template)
- Please note, facilities providing services to persons 21 years of age and up, posting this notice is optional.

Guidance for Facilities on Service and Support Animals

Service Animals

"Service animals" are animals that are trained to perform specific tasks to assist individuals with disabilities, including individuals with mental health disabilities. Service animals do not need to be professionally trained or certified. Under the Americans with Disabilities Act, service animals can only be dogs or miniature horses.

Service animals are different from support animals (see below for further information concerning support animals) and the Americans with Disabilities Act is clear that service animals are allowed in all public spaces, businesses, and are not limited to dwellings or residences. In other words, there are few limitations on where service animals would be permitted to go (even within healthcare facilities). This includes locked behavioral health facilities, where service animals are allowed.
Staff members are not permitted to preemptively deny a service animal. All health care facilities are required to make an "individualized assessment" of a service animal's behavior and its handler's ability to care for it. This means that staff should observe the behavior of the service animal over time and document specific concerns, if any arise. Facility staff are only authorized to deny service animals in limited circumstances such as if it becomes clear that the animal poses a threat to others through aggressive behavior or if the animal is not being cared for by its handler. The reasons for denial of a service animal should be carefully documented by facility staff and clearly communicated to the handler.
Unless there is a reason to believe that an animal poses a threat to others, facility representatives can only ask two questions to determine whether an animal qualifies as a service animal:

- Is the animal required because of the handler's disability?
- What work or task the animal has been trained to perform?

The reasonable accommodation process does not apply to service animals as there is a presumption that they are allowed. In other words, facility staff have less flexibility in making determinations regarding service animals. For example, staff members are not permitted to request documentation for a service animal. Service animals are not required to be formally trained, nor must they wear a special tag or vest. If the client affirmatively answers the two questions above, the animal would be considered a service animal under the law and should be allowed in the facility unless one of the legal justifications for denial applies (see further below).

Support Animals

"Support animals" are animals that provide emotional, cognitive, or other similar support to an individual with a disability. A support animal does not need to be trained or certified.

Current fair housing act (and regulations) indicate that support animals should be allowed in any dwelling or housing accommodation, subject to limited exceptions. The law and regulations have a broad definition of dwelling to include essentially any location that is occupied by an individual person as a residence, even on a temporary or short-term basis. For example, the California Code of Regulations includes language describing that a "room used for sleeping purposes" would be considered a dwelling. However, this specific issue continues to evolve. Therefore, we recommend that facilities develop policies to address this issue. The following is provided as guidance that should be considered.

If a facility has a "no pets" policy, any client may request a "reasonable accommodation" to allow their support animal in the facility. Requests for reasonable accommodation do not have to be in writing and do not require any specific keywords. However, facilities should promptly address these requests.
Evaluating reasonable accommodation(s) should be an interactive process between the requester and the facility staff. If the facility staff members do not understand the initial request, they should continue to work with the requester until they can understand how the support animal will assist with the requester's disability-related need. Staff members can request documentation regarding the client's disability and the need for the support animal. This documentation should only be requested if the disability and/or need for the animal are not already apparent. Facility staff can also require that emotional support animals be licensed and/or vaccinated according to state and local laws that apply to all other animals.

The reasonable accommodation process allows staff members more flexibility in making determinations on support animals. However, if the connection between the disability-related need and the support animal is readily apparent, or if the requester submits appropriate documentation establishing this connection, staff members should allow the support animal, unless one of the legal justifications for denial applies (see below). If the connection is not readily apparent, and the requester does not submit appropriate documentation, then the individual's request could possibly be denied (pending submission of documentation).

Choosing to Deny a Service or Support Animal

We reiterate that denials for both a service or support animal must be based on an individualized assessment that relies on objective evidence about the specific animal's or handler's actual conduct. A service or support animal cannot be denied based solely on the animal's breed. Notably, determinations cannot be made on evidence that is so old it is not credible or reliable, or on mere speculation or fear about the types of harm or damage an animal may cause or on evidence about harm or damage that other animals have caused. The recommendation is that the animal must be allowed but if there is evidence that the owner cannot provide care, the animal is aggressive etc., then the facility should document such behavior and assess whether the animal should remain. If facility staff decide to deny reasonable accommodation for a support animal or deny access to a service animal, they must provide a specific legal justification to the client.

Examples of specific legal justifications include the following:

- Fundamental Alteration
- Permitting the animal would alter the essential nature of the program.
- Undue Burden
- Permitting the animal would cause significant difficulty or expense.
- Direct Threat
- Permitting the animal would lead to significant risk of substantial bodily harm to the health or safety of others or would cause substantial physical damage to the property of others, and that harm cannot be sufficiently mitigated or eliminated by reasonable accommodation.

In cases when facility staff are denying an animal because the requester fails to establish the connection between their disability-related need and the support animal, facility staff should explain why they believe

the connection was not established but would not be required to cite one of the specific legal justifications above. Also, to the extent practical, if an animal requires removal, efforts should be made to ensure that it is retrievable by the owner.

In all cases, facilities need to make (and document) case-by-case determinations. The decision should not assume the denial of either service or support animals unless there is a legitimate reason for such a decision. The regulations do not provide specific requirements for how facility staff should communicate a denial to the requester, but our recommendation is that facilities provide the requester with a written summary of the reasons for the denial and include a copy of this summary in the requester's file. For any non-English speaking individuals, it is also recommended that if feasible, the facility should attempt to provide this information in the individual's preferred language.

Individuals who feel they have been wrongfully denied a service or support animal can file complaints with the U.S. Department of Justice, the U.S. Department of Housing and Urban Development, the California Department of Fair Employment and Housing, and the California Civil Rights Department. They may also file suit in state, federal, or small claims court or seek other legal representation. Additionally, individuals can choose to file a grievance or complaint through the appropriate patient advocacy agency. For this reason, it is important that facility documentation be comprehensive and detailed as to the reasons for any denial.

The information provided above is a summary of applicable law, regulations, and is intended as guidance. In developing policies and procedures, it is recommended that facility representatives utilize the legal guidelines that can be found in Cal. Code Regs. Title 2 § 12005, Cal. Code Regs. tit. 2 § 12176-12181, Cal. Code Regs. Title 2, § 12185, Cal. Code Regs. Title 2 § 14020, Cal. Code Regs. Title 2 § 14331, 28 C.F.R. § 36.104, 28 C.F.R. § 36.302, 28 C.F.R. § 36 app A to Part 36, 28 C.F.R. § 36 app C to Part 36. •