General Assistance Recovery Supports Program (GA RSP)

Reconsideration Form

Please mail or fax this form to:
Department of Mental Health and Addiction Services
Attn: GA Recovery Supports Program Manager
Health Care Systems
410 Capitol Avenue, P.O. Box 341431
Hartford, CT 06134
Fax # (860) 418-6730

Name of applicant requesting reconsideration: _____

Phone #: _____ Encounter #: _____

Current mailing address: _____

_____

Treatment program: _____ Program phone #: _____

Name of primary clinician: _____ Program fax #: _____

Explanation of Request for Reconsideration: Please state why you feel your original GA RSP request decision should be reconsidered. Your provider or anyone else you choose may assist you in filling out this form. You may submit supporting documentation and use additional sheets of paper if needed. Upon receiving this request, DMHAS will make a decision and notify you and your treatment provider within five business days.

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Applicant's Signature: _____ Date: _____

Preparer's Signature: _____ Date: _____

FOR DMHAS USE ONLY

Date request received: Date decision reported to individual, ABH, and Provider:

Disposition of request: