

GRIEVANCE or APPEAL REQUEST

This form is used to file a Grievance or to request an Appeal. If you need assistance in completing this form, you can request help from your provider or by calling Consumer Assistance at (800) 779-0787. **A signed *Authorization for Release of Confidential Information* needs to be submitted along with this form.** The Grievance or Appeal Request can be submitted to your provider (MD, case manager, clinician, the Program Supervisor, etc.) or mailed directly to Consumer Assistance at: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606. **Please fill out both sides of this form.**

I wish to file: (choose one) Grievance Appeal

Check here if you are requesting that your Appeal be processed through the Expedited Appeals Process (see requirements for an Expedited Appeal)

Your address and phone number are important. We need this information to contact you about the outcome of your Grievance or Appeal. **PLEASE PRINT:**

Your Name: _____

Your Address: _____

Your Daytime Phone: _____ Date of Birth: _____

May we leave a message at the above #? Yes No

Current Provider: _____

If Applicable, Person Representing You: _____

Their Address: _____

Their Daytime Phone: _____



Please answer the following questions. Attach additional pages if needed.

What is the problem? _____

What have you done to try to resolve the problem? _____

What would you like the solution to be? _____

Consumer (or Consumer's Representative) Signature

Date

You will not be subject to discrimination or any other penalty for filing a Grievance or Appeal. Your confidentiality will be protected at all times in accordance with State and Federal law. You may request a State Fair Hearing following the completion of the Appeal Process.