ALCOHOL, DRUG & MENTAL HEALTH SERVICES
MANUEL JIMENEZ, MA, MFT, DIRECTOR

Quality Assurance Office
Consumer Assistance
2000 Embarcadero Cove, Suite 400
Oakland, California 94606
(510) 567-8100 / TTY (510) 567-6884
Toll Free: 1 (800) 779-0787
FAX: (510) 639-1346

GRIEVANCE AND APPEALS PROCESS & REQUEST FORM

If you have a concern or problem or are not satisfied with your mental health services, the Mental Health Plan (MHP) wants to be sure your concerns are resolved simply and quickly. You or your representative may file a Grievance or Appeal, orally or in writing, with your provider, or with the Consumer Assistance office at 1(800) 779-0787. **Please use the attached Grievance and Appeal Request Form to file a Grievance or to request an Appeal. You will not be subject to discrimination or any other penalty for filing a Grievance or Appeal.**

A **Grievance** is defined as an expression of unhappiness about anything regarding your specialty mental health services that are not one of the problems covered by the Appeal and State Fair Hearing processes described below. Examples of grievances might be as follows: the quality of care of services provided, aspects of interpersonal relationships – such as rudeness of an employee, etc. **Steps to file a Grievance:**

- File a Grievance orally or in writing. Oral grievances do not have to be followed up in writing. You may authorize another person to act on your behalf.
- You will receive a written acknowledge of receipt of your Grievance.
- The MHP has 60 days after the receipt of your Grievance to review it and notify you or your representative in writing about the decision.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is for your benefit.
- You may file a Grievance at any time.

An **Appeal** is a request for a review of a decision that was made by the MHP or your provider that modifies or denies a requested specialty mental health service (SMHS) and/or a reduction, suspension, or termination of a previously authorized service. The decision made by the MHP about your specialty mental health services may be described in a **Notice of Action (NOA)** letter sent or given personally to you. You will not always get a NOA. **Steps to file an Appeal:**

- File an Appeal in person, on the phone or in writing within 90 days of the date of a NOA. If you file the Appeal in person or by telephone, you must follow it up with a signed written Appeal. If you did not receive a NOA, there is no deadline for filing; so you may file at any time. You may authorize another person to act on your behalf.
- Upon request, your benefits will continue while the Appeal is pending IF you file the Appeal within 10 days from the date the NOA was mailed or given to you.

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- You will receive a written acknowledge of receipt of your Appeal.
- The MHP has 45 days after the receipt of your Appeal to review it and notify you or your representative in writing about the decision.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is for your benefit.

An **Expedited Appeal** can be requested <u>if you think waiting 45 days will jeopardize your life, health, or ability to attain, maintain or regain maximum function</u>. If the MHP agrees that your appeal meets the requirements for an Expedited Appeal, the MHP will resolve it within 3 working days after the Expedited Appeal is received. **Steps to file an Expedited Appeal:**

- File an Appeal in person, on the phone or in writing within 90 days of the date of a Notice of Action (NOA). Verbal and in person requests for Expedited Appeals do not have to be put in writing. You may authorize another person to act on your behalf.
- Upon request, your benefits will continue while the Expedited Appeal is pending IF you file the Appeal within 10 days from the date the NOA was mailed or given to you.
- You will receive a written acknowledgement of receipt of your Expedited Appeal.
- The MHP has 3 days after the receipt of your Expedited Appeal to review it and notify you or your representative in writing about the decision.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is for your benefit.
- If the MHP decides that your appeal does not qualify for an Expedited Appeal, they will notify you right away verbally and in writing within 2 calendar days. Your appeal will then follow the Standard Appeal process.

You have a right to a **State Fair Hearing**, an independent review conducted by the California Department of Social Services, if you have completed the MHP's Grievance and/or Appeals process and the problem is not resolved to your satisfaction. A request for a State Fair Hearing is included with each Notice of Action (NOA); you must submit the request within 90 days of the postmark date <u>or</u> the day that the MHP personally gave you the NOA. You may request a fair hearing whether or not you have received a NOA. To keep your same services while waiting for a hearing, you must request the hearing within ten (10) days from the date the NOA was mailed or personally given to you or before the effective date of the change in service, whichever is later. You may also request a State Fair Hearing by calling 1(800) 952-5253, sending a fax to (916) 651-5210 or (916) 651-2789, or writing to:

Department of Social Services/State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430.

For more detailed information on the Grievance or Appeals process, please ask your provider for a copy of *Guide to Medi-Cal Mental Health Services*. For questions or assistance with filling out forms, you may ask your provider or call:

Consumer Assistance: 1(800) 779-0787

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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 or Patient's Rights at (510) 835-2505. **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:____

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

What is the problem? ____

____

____

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____

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

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____

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 Grievance or Appeal Process.

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

(Please fill out both sides of this form)

____ ____________
Consumer's Last Name First Name Middle Name Date of Birth

____ ____________
Street Address City Zip Code Daytime Telephone

____

I, the undersigned, hereby authorize the release of my confidential information, including medical and psychiatric records, from:

____ ____________
Health Care Provider Name Telephone

____ ____________
Street Address City/State Zip Code FAX # (if known)

to: ACBHCS – QA Office
Consumer Assistance
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

for the purpose of resolving my grievance or appeal request. I further authorize you to provide such copies thereof as may be requested.

This authorization is subject to the following limitations (check one):

☐ All medical records

☐ Confined to records regarding treatment from the period from _______ to ______

☐ Confined to records regarding admission and treatment for the following medical condition or injury:____

☐ Confined to the following specified information: ______________________________

____

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This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate six (6) months from the date of consent. The signer may revoke this release in writing or by verbally informing Consumer Assistance.

____ ____________

Signature of Consumer, Legal Guardian, Representative (Circle one) Date

____ ____________

Signature of Witness Date

Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure.