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:____________________________________________________

Consumer Assistance
Toll Free: 1 (800) 779-0787
California Relay Service, Dial 711
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.