

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.