

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES
GRIEVANCE/APPEAL/EXPEDITED APPEAL FORM

Information regarding the Problem Resolution Process and Language Taglines are attached.
Please submit this page only (Front and Back)

Date: _____ **Name:** _____

Person for whom this form is being submitted (if different from self): _____

Address: _____ **Phone (or message phone):** _____

Health plan: **Medi-Cal** **Private Insurance** **None** **Other** _____

If grievance, where did incident happen? _____

If Medi-Cal appeal, what action do you want us to review? _____

(Attach copy of notice of action if you have one)

Grievance **Appeal** **Expedited Appeal (Check what applies)** Briefly summarize each of your concerns. Include dates, witness names and details about what happened.
For assistance with completing this form, please contact the Patients' Rights Office at (209) 525-7423.

What is the problem?

What do you want to see happen?

Who have you talked to?

Please print and sign your name:

Date signed:

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INFORMATION BELOW TO BE COMPLETED BY STAFF:

Grievance/Appeal /Expedited Appeal#: _____
(circle one)

Incident Location (e.g., unit, program) or Action to Review: _____

Health plan verified: Medi-Cal Private Insurance None Other _____

MEDICAL RECORD NO. (if applicable): _____

STANISLAUS COUNTY BEHAVIORAL HEALTH & RECOVERY SERVICES PROBLEM RESOLUTION PROCESSES FOR MEDI-CAL BENEFICIARIES

Stanislaus County Behavioral Health & Recovery Services (“Plan”) is committed to providing Medi-Cal beneficiaries (“members”) the necessary services and support to attain and maintain the most effective services. If you have a grievance about behavioral health services, you may use the grievance, appeal or expedited appeal process described below. You may request a State Fair Hearing within 120 days after completion of the appeal process. Your grievance or appeal will be handled as quickly and simply as possible. It will be kept confidential in accordance with State laws and department policies and procedures. You will not be subject to discrimination or any other penalty for filing a grievance or appeal. You may authorize another person, including your legal representative, to act on your behalf in the grievance or appeal process. You may present supporting evidence, in person or in writing, if desired.

GRIEVANCE

- Try to resolve the issue simply and quickly at the informal level by talking to those who are directly involved and best able to help; for example, the clinician or other staff person. If this is undesirable or unsuccessful, ask to speak to that person’s supervisor.
- If the problem is not resolved at the staff or supervisor level, speak with the receptionist or program coordinator.
- If the issue cannot be resolved informally, you may submit your grievance in writing on the appropriate form, or orally by calling Patients’ Rights at (209) 525-7423.
- Forms and self-addressed envelopes are readily available at all provider sites. You may request a form be mailed to you or request assistance in completing the form, by calling Patients’ Rights at (209) 525-7423 or the Plan Administrator at (209) 525-6225.
- You will receive written notice when your grievance is received. Your concerns will be investigated and resolved within 90 days. You or your representative will be involved in the resolution process.
- You will receive a letter summarizing the investigation process, findings, action plan, and grievance decision.

APPEAL

- If the Plan (1) denies or limits authorization of a requested service, including the type or level of service; (2) reduces, suspends or terminates an authorized service; (3) denies payment for a service, in whole or in part; (4) fails to provide services in a timely manner, or (5) fails to act within timeframes for disposition of grievances and resolution of appeals, the Plan has taken an action. You are then entitled to file an appeal, which is a request for review of an action.
- You must file your appeal within sixty (60) days from the date the adverse benefit determination you want reviewed was taken.
- You may submit your appeal in writing on the appropriate form, or orally by calling Patients’ Rights at (209) 525-7423. If you make an oral appeal it must be followed up with a written, signed appeal form. Forms are available in the lobbies of all Plan service providers or will be mailed to you, upon request. If you received a notice of adverse benefit determination, please attach a copy of it to the form as well as any written materials that support your point of view.
- You will receive written notice when your appeal is received.
- Your appeal will be reviewed within 30 calendar days. You will receive a letter summarizing the review process, findings, appeal decision and date appeal decision was made.

- If the appeal decision is not wholly in your favor, you have the right to request a State Fair Hearing. You may request a Fair Hearing by calling 1-800-952-5253.

Expedited Appeal

- Will be used when the Plan, your provider or you determine that taking the time for a standard appeal resolution could seriously jeopardize your life, health or ability to attain, maintain, or regain maximum function.
- You may file the request for an expedited appeal orally without following with a written request.
- You will not be subject to discrimination or any other penalty for filing an expedited appeal.
- Resolve an expedited appeal and notify the affected parties in writing, no later than 72 hours after the Plan receives the appeal. This timeframe may be extended by up to 14 calendar days if you request an extension or the Plan needs additional information and that the delay is in your best interest. The Plan will notify you of the extension and the reason in writing.
- You will receive a written notice of the disposition and all efforts will be made to provide you with an oral notice.
- If the Plan denies a request for an expedited appeal resolution, the Plan shall: Transfer the expedited appeal request to the timeframe for appeal resolution and make reasonable efforts to give you prompt oral notice of the denial of the expedited appeal request and provide written notice within two calendar days of the date of the denial.

State Fair Hearing

- Can be requested when you filed an appeal and received an appeal resolution letter telling you that your MHP denies your appeal request or an exhaustion of an expedited appeal process
- Your grievance, appeal, or expedited appeal wasn't resolved in time
- May be requested also whether or not the beneficiary has received a notice of adverse benefit determination.
- You only have 120 days to request a fair hearing. The 120 days start either the day after the MHP personally gives you its appeal decision notice, or the day after the postmark date of the MHP appeal decision notice.
- After you request for a fair hearing, you will receive written notice within 90 days about your case.

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-376-6246 (TTY: 711).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call 1-888-376-6246 (TTY: 711).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-376-6246 (TTY: 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-376-6246 (TTY: 711).

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-376-6246 (TTY: 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-888-376-6246 (TTY: 711) 번으로 전화해 주십시오.

繁體中文(Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-376-6246 (TTY: 711)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1-888-376-6246 (TTY (հեռատիպ)՝ 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-376-6246 (телетайп: 711).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. ب 1-888-376-6246 (TTY: 711) تماس بگیرید.

