

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

To access our electronic form, please scan here:



Information regarding the Problem Resolution Process and the Notice Of Availability Of Language Assistance Services And Auxiliary Aids And Services are attached.

Please submit this page only (Front and Back)

Date: _____ Name: _____

Date of Birth: _____

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

Address: _____

Phone (or message phone): _____

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 which 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:

INFORMATION BELOW TO BE COMPLETED BY STAFF:
Grievance/Appeal /Expedited Appeal: # _____
(circle one)
Incident Location (e.g., unit, program) QS Action to Review:

Health plan Medi-Cal Private None Other _____
verified: Insurance
MEDICAL RECORD NO. (if applicable): _____

STANISLAUS COUNTY BEHAVIORAL HEALTH & RECOVERY SERVICES PROBLEM RESOLUTION PROCESSES FOR MEDICAL 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, appeal or expedited appeal. You may provide written authorization for another person, including your legal representative, to act on your behalf in the grievance, appeal, or state fair hearing 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 30 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.
- 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 your request for a fair hearing, you will receive written notice within 90 days about your case.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

English

ATTENTION: If you need help in your language call 1-888-376-6246 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-888-376-6246 (TTY: 711). These services are free of charge.

العربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-888-376-6246 (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريـل والخط الكبير. اتصل بـ 1-888-376-6246 (TTY: 711). هذه الخدمات مجانية.

Հայերեն (Armenian)

ՈՒՇԱԴԻՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-888-376-6246 (TTY: 711). Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված կյուրթեր: Չանգահարեք 1-888-376-6246 (TTY: 711) Այդ ծառայություններն անվճար են:

ខ្មែរ (Cambodian)

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-888-376-6246 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-888-376-6246 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語 (Japanese)

注意日本語での対応が必要な場合は 1-888-376-6246 (TTY: 711) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。1-888-376-6246 (TTY: 711) へお電話ください。これらのサービスは無料で提供しています。

한국어 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-888-376-6246 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-888-376-6246 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian)

ປະກາດ:

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ເຮົາຮູ້ທ່ານ

ປີ 1-888-376-6246 (TTY: 711).

ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມິໂຕພິມໃຫຍ່ ໃຫ້ເຂົ້າຫາເບີ
1-888-376-6246 (TTY: 711).
ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih
qiemx longc mienh tengx faan benx meih nyei waac nor
douc waac daaih lorx taux 1-888-376-6246 (TTY: 711).
Liouh lorx jauv-louc tengx aengx caux nzie gong bun
taux ninh mbuo wuaaic fangx mienh, beiv taux longc
benx nzangc-pokc bun hluo mbiutc aengx caux aamz
mborqv benx domh sou se mbenc nzoih bun longc.
Douc waac daaih lorx 1-888-376-6246 (TTY: 711).
Naaiv deix nzie weih gong-bou jauv-louc se benx
wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-
888-376-6246 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ
ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ — ਜਿਵੇਂ ਕਿ ਬੋਲ ਅਤੇ ਵੱਡੇ ਅੱਖਰਾਂ ਵਾਲੇ ਦਸਤਾਵੇਜ਼
— ਵੀ ਉਪਲਬਧ ਹਨ। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем
родном языке, звоните по номеру 1-888-376-6246
(линия TTY: 711). Также предоставляются средства

и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-888-376-6246 (линия ТТУ:711). Такие услуги предоставляются бесплатно.

Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-888-376-6246 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-888-376-6246 (TTY: 711). Estos servicios son gratuitos.

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-888-376-6246 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-888-376-6246 (TTY: 711). Libre ang mga serbisyonang ito.

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-376-6246 (TTY: 711). นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-376-6246 (TTY: 711). ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Українська (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-888-376-6246 (ТТУ: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-888-376-6246 (ТТУ: 711). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-888-376-6246 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-888-376-6246 (TTY: 711). Các dịch vụ này đều miễn phí.