Behavioral Health
Department
Alameda County Health

Consumer Grievance and Appeal Procedure Manual

(For use by Alameda County Behavioral Health Department (ACBHD) and ACBHD Contractors)

July 2025

Table of Contents

Introduction 2

Structure of the Manual 2

1: Background: Grievances, Appeals and State Fair Hearings 3

Table 1: Timeline for Grievance, Exempt Grievance, Appeal, Expedited Appeal, and State Fair Hearing 5

2: Information Provided to Beneficiaries 6

3: Receipt of the Grievance or Appeal Request 7

4: Acknowledgment of Receipt 9

5: Investigation 11

6: Resolution and Decision 12

7: Failure to Meet Required Time Frames 13

8: Grievance Process Exemptions 13

9: Retention of Records 14

10: ACBHD-Contracted Providers with Internal Grievance Resolution Process 15

11: ACBHD Reporting 16

Appendix A: Forms and Letters 18

GRIEVANCE AND APPEALS PROCESS 19

GRIEVANCE or APPEAL REQUEST 22

Authorization for Release of Confidential Information 24

GRIEVANCE CALL FORM 26

Letter of Acknowledgment-Appeal 27

Letter of Acknowledgment-Grievance 29

Investigation Notes 30

NOTICE OF GRIEVANCE RESOLUTION 31

NOTICE OF APPEAL RESOLUTION-Upheld 32

NOTICE OF APPEAL RESOLUTION-Overturned 34

NON-DISCRIMINATION NOTICE 40

NOTICE OF AVAILABILITY LANGUAGE TAGLINES 42

NOTICE OF ADVERSE BENEFIT DETERMINATION About Your Treatment Request-Timely Access 45

Expedited Appeal Request: Letter of Denial 47

File Document Check List 49

Appendix B: ACBHD Grievance and Appeal System Policy 50

Appendix C: Other Agency Contacts 51

Appendix D: Legal Rights of Patients and Tenants 57

Appendix E: Code of Regulations 62

Introduction

As an operator of a State-recognized Behavioral Health Plan (BHP), Alameda County Behavioral Health Department (ACBHD) is required by the California Department of Health Care Services (DHCS MHSUDS Information Notice No.18-010) and ACBHD Consumer and Appeal Grievance and Appeal System policy #3001-1-1) to have a Grievance and Appeal Process that enables a beneficiary to seek resolution to a problem or concern about any issue related to the BHP's performance of its duties, including the delivery of specialty health services and substance use disorder services.

ACBHD is committed to providing high quality service to beneficiaries and to offering a problem resolution process that is easy to access, timely, and responsive to the concerns and experiences of beneficiaries. This manual describes the process for addressing such concerns or problems.

Structure of the Manual

This manual is intended for use by the BHP which includes both County and County-Contracted Providers. It provides a detailed description of the steps that are taken to advertise, receive, and resolve beneficiary grievances and appeals received by the BHP. The manual also provides summary information regarding the complaint procedures of other public and private agencies that beneficiaries may connect with, and an overview of certain other consumer rights.

Required forms and documents are provided in the Appendix of Forms and Documents at the end of the manual. A document icon appears by every form that is referred to and clicking on the highlighted hyperlink on the name of the form will take the reader directly to the referenced documents.

Many of the steps included in this manual are required to be tracked in the ACBHD Grievance and Appeal Log. Information that must be entered into the electronic log is highlighted with a computer icon.

1: Background: Grievances, Appeals and State Fair Hearings

The State Regulations distinguish four kinds of "problems" that are covered by the Beneficiary Problem Resolution Process.

A **Grievance** is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination described below in the Medi-Cal Appeal process. The definition specifies that grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the BHP to make an authorization decision. There is no distinction between a formal and informal grievance. A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an Adverse Benefit Determination. The BHP cannot discourage the filing of a grievance. Consumers do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. Even if the consumer expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance. As with other grievances, these grievances will be analyzed to monitor trends.

Exempt Grievances are grievances received over the telephone or in-person by BHP. Exempt grievances are resolved to the beneficiary's satisfaction by the close of the next business day and are exempt from the requirement to send a written acknowledgement and disposition letter. Grievances received via mail by the BHP, are not exempt from the requirement to send acknowledgment and disposition letter in writing. If the BHP receives a complaint pertaining to an Adverse Benefit Determination, the complaint is not considered a grievance, and the exemption does not apply.

An **Appeal** is a review of an Adverse Benefit Determination by the BHP. An Adverse Benefit Determination is defined to mean any of the following actions taken by ACBHD or an ACBHD-contracted provider (Refer to ACBHD Notice of Adverse Benefit Determination [NOABD] policy on issuing NOABD's):

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure to act within the required timeframes for standard resolution of grievances and appeals; or

- The denial of a beneficiary's request to dispute financial liability.

When any of the above actions occurs, the BHP is required to issue a NOABD. However, a beneficiary does not have to have received a NOABD in order to request an appeal. An appeal may be initiated orally but must be followed with a written appeal.

An important note about "Appeals": Appeals are only available when a client receives a NOABD or any action occurs that warrants a NOABD, even if the NOABD was not issued. Appeals are not available to beneficiaries that are not happy with the results of their grievances. In addition, Fair Hearings are not available to beneficiaries who are unhappy with their grievance results.

An **Expedited** Appeal is an appeal that is addressed in a highly expedited fashion because taking the time for a standard resolution of an appeal could seriously jeopardize the consumer's life, health, or ability to attain, maintain or regain maximum function. (See timeframes below in Table 1.) An expedited appeal can be made orally without requiring a written appeal to follow. If the BHP denies a request for expedited appeal resolution, the BHP shall:

(1) Transfer the expedited appeal request to the timeframe for standard appeal resolution.
(2) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within seventy-two hours of the date of the denial. A copy of the Expedited Appeal Request – Letter of Denial can be found in Appendix A. The written notice of the denial of the request for an expedited appeal is not a Notice of Appeal Resolution.

A **State Fair Hearing** is a formal hearing conducted by the State of California. Beneficiaries have a right to request a Fair Hearing if they have availed themselves of the BHP's problem resolution process for NOABD's and Appeals and are dissatisfied with the resolution. The BHP and behavioral health providers must abide by any decision reached through a State Fair Hearing.

For more information on these concepts, and additional definitions, see the Grievance and Appeal policy

A note about Patients' Rights: Services and treatment consumers receive while hospitalized, residing in a licensed institutional setting, and certain other aspects of client care are covered by Patient's Rights and handled through a different process. In Alameda County, assistance with Patients' Rights is provided by Health Association. More information about Patients' Rights is provided in Appendix D of this manual.

Table 1: Timeline for Grievance, Exempt Grievance, Appeal, Expedited Appeal, and State Fair Hearing

Process	Acknowledge Receipt	Resolution
Grievance Beneficiary may file orally, or in writing.	5 business days: To send acknowledgment letter.	30 calendar days: from receipt to BHP decision.
Exempt Grievance Beneficiary may file orally by phone or in-person.	By close of next business day: To verbally acknowledge grievance	By close of next business day: To log and verbally resolve the grievance to the beneficiary's satisfaction.
Appeal Beneficiary may file an oral Appeal, but a written Appeal is required to follow.	5 business days: To send acknowledgment letter.	30 calendar days: from receipt to BHP decision. *Must notify beneficiary of right to file a Fair Hearing after Appeal process has been exhausted.
Expedited Appeal Beneficiary may file an Oral Expedited Appeal ***without*** written to follow.	Required when taking time for a standard Appeal could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.	72 hours: To resolve and notify affected parties (of resolution) in writing ***and*** make reasonable effort to provide oral notification.
State Fair Hearing Beneficiary must contact the State Fair Hearing (1-800-952-5253)	BHP must notify beneficiary of right to file a Fair Hearing after Appeal processes have been exhausted.	Beneficiaries may request within 120 calendar days of a BHP decision, after exhausting the BHP Appeal Process; If the hearing is requested within 10 days of receipt of a NAR, under certain circumstances, the level of services will be maintained pending the outcome of the hearing.

2: Information Provided to Beneficiaries

Beneficiaries must have adequate information about the BHP's Grievance and Appeal process to be able to take advantage of the process if they so choose.

Information about how to make a grievance or appeal must be available in the BHP's Consumer Materials (i.e. Guide to Medi-Cal Services) available at all sites where BHP services are delivered. This includes County-operated and all County-contracted provider sites. Each site must prominently display a poster or posters in all of Alameda County's threshold languages provided by the BHP which contain information about ACBHD's grievance and appeal process and the ACBHD: Consumer Assistance phone number.

Note: ACBHD-contracted providers may also have their own internal consumer grievance resolution process which must adhere to the process outlined in this manual which meets State and Federal regulations. (See Section 11)

Grievances may be filed at any time with ACBHD by the consumer and/or their authorized representative. This includes beneficiaries aged twelve (12) or over, parents/guardians of children and youth receiving services, a consumer-designated representative (i.e. family member, friend, service provider, other client, or trained advocate) may file a grievance or assist the consumer in the process at any time. If the consumer-designated representative is not employed by ACBHD or an ACBHD contactor, consumer confidentiality must be protected; the consumer must give verbal consent and/or sign an Authorization for Release of Confidential Information form, available at all sites, in order to allow ACBHD to discuss the issue(s) with the representative.

Grievances to ACBHD may be filed orally, in writing, or in person by using ACBHD's Grievance or Appeal Request form, available at all provider sites. Grievances may be filed by a consumer or their designated representative to ACBHD as follows:

By phone: (800) 779-0787 Consumer Assistance Line

Via US mail: 2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

In Person: By visiting the provider site to obtain forms and assistance,

OR

By visiting Consumer Assistance at Mental Health Association, 2855 Telegraph Ave., Suite 501, Berkeley, CA 94705

Assistance filing a grievance may also be obtained by calling the Consumer Assistance Line listed above. Grievances filed orally or in person will be entered on a grievance call form by the staff member receiving the grievance.

All sites must also have available the ACBHD form for making a written request for a grievance or appeal and pre-addressed envelopes. The information, forms and envelopes must be available to the beneficiary or their representative without them having to make a verbal or written request to anyone for them. This information must also notify beneficiaries that they may authorize another person to act on their behalf, that the process maintains their confidentiality, and that the beneficiary is not subject to discrimination or any other penalty for filing a grievance, appeal or expedited appeal. The written form collects information on the person filing the grievance or appeal, information about the problem, and suggestions for its potential resolution.

Whenever the BHP issues a NOABD of any type to a beneficiary, it must include information about the Appeal process and about State Fair Hearings and how to access them as well as the following three enclosures: Your Rights Under Medi-Cal, Nondiscrimination Notice, and Language Assistance.

Copies of Information about the Process, the Grievance/Appeal Request Form, and Release of information can be found in Appendix A.

3: Receipt of the Grievance or Appeal Request

Grievance or Appeal requests are summarized and collected on a Grievance/Appeal Call Form. (Note: All consumer appeals must be directed to ACBHD's Consumer Assistance line). The written request form collects information on the person filing the grievance or appeal, about the problem being reported, and the beneficiary's desire for potential resolution. If the grievance or appeal is made by phone, the receiver must record the information that is on the grievance call form. This includes:

- the contact information for the person making the grievance or appeal including name, address, a daytime phone number and the beneficiary's date of birth.
- information about the agency or individual that currently provides services to the person.
- a summary of the issue or problem.
- any steps they have already taken to resolve the issue or problem; and,
- how the beneficiary or the person making the grievance would like to have the problem resolved.

In some cases, the beneficiary or their representative may leave a message on the ACBHD's Consumer Assistance Line or a contracted provider's voice mail with some but

not all of this information. The recipient should return the call within 24 hours and complete the collection of information, confirming what has been mentioned in the call as well as gathering any additional information.

Discrimination Grievances

Beneficiaries, prospective beneficiaries and members of the public can file a Discrimination Grievance with:

a) ACBHD and/or DHCS if there is a concern of:
    I. Discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. (Welf. & Inst. Code § 14727(a)(3).)
    II. Failure to provide trans-inclusive health care, meaning healthcare that is consistent with the standards of care for individuals who identify as transgender, gender diverse or intersex (TGI). (Welf. & Inst. Code § 14197.09)
b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (Welf. & Inst. Code § 14727(a)(5).)

ACBHD does not require a beneficiary to file a Discrimination Grievance with ACBHD before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

The ACBHD Quality Assurance (QA) Grievance Coordinator is responsible for all discrimination grievances. Discrimination grievances are completed by the QA Grievance Coordinator in consultation with the ACBHD Health Equity Officer and/or Compliance Officer, as appropriate, to ensure equitable resolution of all discrimination-related complaints and for ensuring compliance with federal and state non-discrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

See the ACBHD Reporting section of this manual for reporting requirements.

Release of Information

In order to investigate the problem, the recipient will need the consent of the beneficiary to release information. If the complainant is the beneficiary, they may provide this consent verbally. If the grievance or appeal is being made by a representative, the beneficiary must consent that the representative is able to represent them. Oral consent is sufficient for BHP provider representatives. Written consent is required for non-BHP representatives.

All information received will be maintained with full respect to all regulations that assure confidentiality and security. Beneficiaries and/or their representatives may request from

ACBHD or an ACBHD contractor *at any time* a copy of any documents and records considered during the grievance/appeal process.

Calls Regarding Other Matters

In some instances, callers may have complaints or concerns about an agency or service that is not under the BHP. Examples of these include complaints about medical care at Highland Hospital, care at a non-County facility such as Herrick Hospital or the VA, an incident with law enforcement or at Santa Rita jail, or concerns regarding their housing. A list of agencies and their contact information and complaint processes are included in Appendix C of this manual. The call recipient may provide information to the caller about the appropriate agency to contact.

These calls are not considered grievances or appeals and do not need to be formally logged. However, the ACBHD Consumer Assistance Staff tracks the number and types of calls of this nature to identify areas where greater information to consumers and providers may be beneficial, and to expand or improve the information provided in this manual.

4: Acknowledgment of Receipt

Whether a grievance or appeal is received in writing or verbally, it must be logged and acknowledged in writing and post marked within five (5) calendar days. Therefore, it is extremely important to get a complete address from the caller.

The *date* the grievance or appeal is received will be the date that *sufficient information* needed to identify and follow up with the person making the grievance or appeal is complete and the receiver is able to begin the investigation. If a beneficiary leaves a message on the ACBHD Consumer Assistance Line or contracted provider voice mail but is unable to be reached to confirm the information or complete it, the information will not be considered complete and the time frame for resolution will not begin. If no verbal or written release is given, no investigation may ensue.

A written letter will be sent to the person who has made the grievance or appeal-either the beneficiary or their representative. The letter informs the person making the grievance or appeal that:

- The information has been received.
- It acknowledges the date that the grievance is considered to be received, as well as the name, telephone number, and address of the BHP representative who the beneficiary may contact about the grievance.
- It explains the time frame in which the investigation and resolution will be carried out, in accordance with the corresponding regulations (see Table 1).

If the beneficiary has made an oral grievance, the letter will acknowledge the conversation, and whether verbal consent to release information was received. If verbal consent was not

received, or is not sufficient, the letter will include a copy of the release of information form and request that the beneficiary return the form as soon as possible. In this case, no investigation can begin, and no start date should be on the letter. An attempt to get a written release should always be made, regardless of verbal release.

If the beneficiary is making an appeal and has made the request orally, they will be contacted and told that they shall put their appeal in writing as well. The letter will then include a copy of the form to request an appeal and the release of information. Staff may help them with this process.

Copies of the Letter of Acknowledgment - Grievance and Letter of Acknowledgment-Appeal can be found in the Appendix of Forms. A copy of the Release of Information can be found there as well. A copy of the letter sent to be beneficiary should be kept in the paper file.

ACBHD Consumer Assistance maintains a master log of all BHP grievances and appeals. Contract providers who have an internal grievance resolution process must also maintain a log.

Enter into the log the date and time that the grievance or appeal request was received whether in writing or verbally, along with beneficiary's name, that of the complainant if they are other than the beneficiary, their relationship to the beneficiary, and the provider agency and/or the facility name about which they are complaining. The date of the letter of acknowledgement is also recorded. This date should be no more than one business day after the day the request was received.

The log records the type of grievance or appeal that is being made. Categories and their definitions include:

- **Access** – failure to be given access to a service requested by the beneficiary. These subcategories include:
    - Service not Available
    - Service not Accessible
    - Timeliness of Services
    - 24/7/ Toll Free Access Line
    - Linguistic Services
    - Other Access issues
- **Change of Provider** – a grievance which includes as its desired resolution to change providers due to dissatisfaction with service.
- **Confidentiality** – a concern that the beneficiary's confidential information has been shared inappropriately.
- **Quality of Care** – any of a number of concerns about the treatment the beneficiary has received which may include interpersonal relations as well as the quality of the

site and other issues. All of these fall under grievances. These are subcategorized into:
    - Staff Behavior Concerns
    - Treatment issues or Concerns
    - Medication Concern
    - Cultural Appropriateness
    - Other Quality of Care Issues
- **Other** – These are subcategorized into:
    - Financial - Any issues concerning money, either personal finances or cost of treatment
    - Lost Property
    - Operational - Issue with how the program is being managed.
    - Peer Behaviors - Conflicts with peers.
    - Physical Environment - Issues having to do with treatment buildings and environment.
    - Other Grievance not listed above.

The category "Other" should only be used if the motive for the appeal or grievance does not fit within one of the previous categories. When the Other category is used, the specific reason should be noted in the log. From time to time, ACBHD may choose to create subcategories of greater detail, provided that these can be summarized into the categories above which are required by the State.

5: Investigation

The receiver must investigate the concerns raised in the grievance or appeal before making a determination. The investigation should begin as soon as possible as the investigator is working within a prescribed timeframe. The investigator is likely to need to contact the provider/staff in the matter to determine what occurred from their perspective.

During the course of the investigation, the investigator should document all steps taken, including conversations with the beneficiary, their representative, providers, any witnesses or other persons aware of the circumstances, as well as any documents reviewed, or other research or investigations made to verify or determine what has occurred.

The investigation process is formal and needs to be well documented. However, it is the intent that the investigator is helpful to the beneficiary and the provider/staff in seeking a reasonable and satisfactory resolution whenever possible. In many cases the issue may be one of communication or misunderstanding. The beneficiary's request for resolution should be considered and where possible a rapid action that leads to resolution between provider/staff and beneficiary may be encouraged or supported.

If, in the course of the investigation, the investigator uncovers significant issues related to program compliance, they should consult with the ACBHD QA Office, ACBHD Compliance Officer, or contract provider's compliance officer immediately.

The investigator should always take measures to ensure that the investigation occurs within the prescribed time frame for resolution based on whether the concern is a grievance, appeal or expedited appeal. (See Table 1 above)

Investigation notes should be recorded in the file documenting all communications and actions taken to investigate the grievance or appeal matter. Use a separate notes sheet for each day or activity, and record events such as messages left even if communication was not established.

A brief summary of this process will be entered into the log when the resolution is completed and must include dates of review or review meetings.

6: Resolution and Decision

Once the grievance or appeal has been fully investigated, the investigator will reach a conclusion regarding the matter, and whether any action is required to be taken to resolve the problem or remedy the matter.

The investigator drafts the Decision Letter which includes a summary of the steps that were taken in the investigation and what conclusion or decision was reached about the concern or claim. If the conclusion is that a change of action or correction is needed to address the problem the letter should also state whether this correction or change has already been taken or remains to be taken.

In cases where the grievance was regarding a specific provider, the investigator must also notify the provider of the decision and resolution.

The California DHCS required format for grievance decisions is the Notice of Grievance Resolution Letter which is sent to the beneficiary along with the Nondiscrimination Notice and Language Assistance enclosures. The required format for an Appeal decision is-Notice of Appeal (Upheld or Overturned) which is sent to the beneficiary along with the Notice of Appeal Resolution-Your Rights, Nondiscrimination Notice, and Language Assistance enclosures. All beneficiary notices and a Notification of Decision to a Provider can be found in Appendix A.

Record in the log the date the Decision Letter was sent to the complainant as well as a brief summary of the resolution. If a provider was named or involved in the issue, also

record the date of the Notice of Decision to the provider. Hard copies of both letters should be kept in the file.

If no Decision Letter is able to be issued to the beneficiary or their representative, the notes regarding the resolution should clearly state the reason (e.g., no known contact information). If a letter is sent and the mail is returned due to insufficient address, note in the log that the letter was unable to be delivered, the date the returned letter was received, and keep the returned letter unopened in the file.

7: Failure to Meet Required Time Frames

If the BHP fails to notify the beneficiary of a decision in the time frame permitted, the BHP must issue a NOABD-Grievance and Appeal Timely Resolution which notifies the beneficiary or their representative that the BHP has failed to notify the affected parties within the allotted period and that the beneficiary has a right to request a State Fair Hearing.

Templates for the NOABD Grievance and Appeal Timely Resolution notice along with Your Rights Under Medi-Cal, Nondiscrimination Notice, and Language Assistance enclosures can be found in Appendix A. These forms are issued by the State and should not be changed.

Record in the log the date a NOABD was issued.

8: Grievance Process Exemptions

Grievances received over the telephone or in-person by ACBHD or an ACBHD-contracted provider, that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt, are exempt from the requirement to send a written acknowledgement and disposition letter. Grievances received via mail by ACBHD or ACBHD-contracted providers and/or agencies are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If ACBHD or an ACBHD-contracted agency receives a grievance pertaining to an Adverse Benefit Determination, the complaint is not considered a grievance, and the exemption does not apply. All exempt grievances must be logged by ACBHD and ACBHD-contracted provider agencies. ACBHD-contracted providers and/or agencies must submit the ACBHD Grievance Call Form in lieu of a grievance case file. The Grievance Call Form must include the following information:

1. Date and time of receipt of the grievance
2. Name of the consumer
3. Nature of the grievance

4. Brief description of the resolution of grievance
5. Date and time of resolution
6. Name of agency representative who received and resolved the grievance
7. Agency representative's contact information

ACBHD must ensure that exempt grievances are included its Annual Beneficiary Grievance and Appeal Report (ABGAR) that is submitted to the California Department of Health Care Services (DHCS).

9: Retention of Records

ACBHD and ACBHD-contracted provider agencies shall retain a copy of all grievances in locked administrative files, or stored in a secure electronic file, per requirements in ACBHD's most current Records Retention policy.

As required by the DHCS, ACBHD shall maintain a log of all Medi-Cal grievance/appeals and Behavioral Health Services Act (BHSA) related grievances. Any non-Medi-Cal or non-MHSA grievances shall also be captured on the ACBHD log for tracking purposes and for use in the quarterly patterns report to the ACBHD Quality Improvement Committee. ACBHD-contracted provider agencies shall also maintain a log of consumer grievances. The log shall contain at least the following information, if applicable, on each grievance or appeal:

1. Name of grievant and their representative, if applicable
2. Date received
3. Medi-Cal ID/Social Security Number for Medi-Cal Beneficiaries
4. A general description of the reason for the appeal or grievance
5. Agency/program name or individual provider name
6. Date received
7. Date of each review and/or review meeting
8. Date acknowledgment letter was mailed out
9. Resolution of appeal and/or grievance
10. Date the letter of decision/notification to beneficiary was mailed out
11. Date of Resolution
12. Date NOABD was mailed out
13. Date the letter of decision/notification to provider was mailed out
14. Whether program was funded by MHSA/MHSA issues identified

Each grievance or appeal shall have an individual grievance/appeal case file that includes copies of the following documents as applicable. The file shall be kept separate from the consumer's treatment file.

1. Name of the beneficiary
2. Medical Record # (ACBHD #)
3. Staff name who resolved the grievance/appeal and credentials
4. Documentation of Request for investigation of Grievance or Appeal from Beneficiary or Representative
5. Authorization of Release of Information from beneficiary if needed for resolution of grievance/appeal
6. Letter of Acknowledgment
7. Provider Notice (Grievance/Appeal) Letter
8. Investigation Notes
9. Notice of Grievance or Appeal Resolution to beneficiary with Language Assistance and Nondiscrimination Notice enclosures
10. Notification of Grievance or Appeal Disposition to Provider
11. Supporting Documentation and additional correspondence (emails/records)

10: ACBHD-Contracted Providers with Internal Grievance Resolution Process

Any ACBHD-contracted provider agency's internal grievance process for consumers shall be in compliance with all State and Federal regulations as well as the ACBHD policy and this procedure manual regarding grievance processes including, but not limited to, grievance resolution timelines, notices to consumers, records retention, and logging. Contracted providers may refer to this ACBHD Consumer Grievance and Appeal Manual for guidelines and notice and resolution templates. Contracted providers must not require that consumers use or exhaust their internal grievance process prior to accessing ACBHD's grievance process. Appeals as described above may only be filed with and resolved by ACBHD. Contract providers must direct consumers who wish to file an appeal to the ACBHD Consumer Assistance Line. All ACBHD-contracted providers and/or agencies must maintain a grievance case file for each consumer grievance, which, at a minimum, contains all applicable information and documents listed under Section 9: Retention of Records above.

Upon resolution of a grievance, contracted providers must transmit a copy of all applicable information and documents listed above under Retention of Records above within five (5) days of the grievance resolution date. Submit grievance case files along with the agency representative's name and contact information to the ACBHD Quality Assurance Office Consumer Assistance:

By FAX: (510) 639-1346
By Secure Email: qaoffice@acgov.org
Via US mail: 2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

Contracted provider agencies must maintain a grievance log that is kept current and contains all the applicable information listed under Retention of Records above. The grievance log must capture all consumer grievances whether or not a formal grievance was filed. ACBHD Quality Management will monitor that contracted-provider agency's consumer grievance processes including, but not limited to, provider's consumer grievance resolution policy, grievance log, and/or grievance case files are in compliance with Federal and State regulations and guidelines and this ACBHD policy.

11: ACBHD Reporting

The Grievance and Appeal Resolution Process must include a procedure by which the issues identified as a result of a grievance or appeal is transmitted to the BHP's Quality Improvement Committee for consideration in the quality improvement program.

Not less frequently than quarterly, the ACBHD QA office will produce a report summarizing the number and type of grievances received during the quarter, the timeliness of responses, and reviewing and highlighting any trends or patterns emerging from the data.

On an annual basis, the ACBHD QA office will prepare the mental health ABGAR to the State. The ABGAR is due in October of each year. On a quarterly basis, the ACBHD QA office will prepare the DMC ODS grievance and appeal report to the State. Both reports will follow the State requirements which currently include a summary of the number and types of grievances, exempt grievances, appeals, and expedited appeals received, and the disposition of each, including whether the matter has been referred, resolved or is still pending at the time of the report.

Discrimination Related Grievances

Within (10) calendar days of mailing a Discrimination-related Notice of Grievance Resolution Letter to a beneficiary, QA Grievance Coordinator will submit the following information regarding the complaint to the DHCS Office of Civil Rights:

1) The original complaint.
2) The provider's or other accused party's response to the complaint.
3) Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the BHP.
4) Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.
5) All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the beneficiary.
6) The results of the BHPs investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

The information will be mailed to the following address:

Office of Civil Rights, Department of Health Care Services
PO Box 997413, MS 0009
Sacramento, CA 95899-7413

TGI and Trans-inclusive Healthcare Related Grievances

If a member submits a grievance for failure to provide trans-inclusive health care, the BHP is required to report the grievance to DHCS quarterly. BHP's are also required to submit additional information, as specified by DHCS, that verifies the grievance data reported to DHCS on a quarterly basis when the outcomes of the grievance reported are resolved in the member's favor. The report shall include but is not limited to, the following:

1. Total grievances filed for failure to provide trans-inclusive health care as defined by BHIN 25-019
2. Total grievances resolved in the member's favor
3. Date the grievance was received
4. Name of the individual, position title, affiliation with the BHP
5. Completion date of the refresher training; and
6. Any additional actions taken by the BHP to prevent future complaints

Behavioral Health
Department
Alameda County Health

Appendix A: Forms and Letters

(click here to return to the main section of manual)

GRIEVANCE AND APPEALS PROCESS

If you have a concern or problem or are not satisfied with your behavioral health services, the Behavioral Health Plan (BHP) wants to be sure your concerns are resolved simply and quickly. You or your representative may file a Grievance or Appeal with the Consumer Assistance office at 1(800) 779-0787. You may also ask your provider if they have a process for resolving grievances. **Please use the Grievance and Appeal Request Form to file a Grievance or to request an Appeal.** Please note that appeals may only be filed with Consumer Assistance and *not* with your provider. **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 dissatisfaction about any matter regarding your behavioral 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 may file a Grievance at any time.
- You will receive a written acknowledge of receipt of your Grievance postmarked within 5 days of receipt of the Grievance.
- The BHP has 30 calendar days after the receipt of your Grievance to review it and notify you or your representative in writing about the decision. If resolution of your grievance is not reached within 30 calendar days, you will be provided prompt oral and/or written notification of your rights and specific information on your grievance.

Where to File Your Grievance

- **With Alameda County Behavioral Health Department (ACBHD):**
  By phone: 1-800-779-0787 Consumer Assistance
  For assistance with hearing or speaking, call 711, California Relay Service
  Via US Mail: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
  In Person: By visiting Consumer Assistance at Mental Health Association, 2855 Telegraph Ave., Suite 501, Berkeley, CA 94705

- **With your provider:** Your provider may resolve your grievance internally or direct you to ACBHD above. You may obtain forms and assistance from your provider.

An **Appeal** is a review by the BHP of an Adverse Benefit Determination (ABD).
An **Adverse Benefit Determination** is defined to mean any of the following actions taken by the BHP or a BHP-contracted provider regarding Medi-Cal behavioral health care services: 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2)The reduction, suspension, or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner; 5) The failure to act within the required timeframes for standard resolution of grievances and appeals; or 6) The denial of a beneficiary's request to dispute financial liability. The decision made by the BHP about your behavioral health services may be described in a **Notice of Adverse Benefit Determination (NOABD)** letter sent or given personally to you.

Steps to file an Appeal:

- Only Medi-Cal beneficiaries may file a Standard or Expedited Appeal with ACBHD regarding a NOABD for a Medi-Cal behavioral health service.
- File an Appeal in person, on the phone or in writing within 60 days of the date of a NOABD. If you file the Appeal orally, you must follow it up with a signed written Appeal. If you did not receive a NOABD, 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 calendar days from the date the NOABD was mailed or given to you.
- You will receive a written acknowledge of receipt of your Appeal postmarked within 5 calendar days of receipt of the Appeal.
- The BHP has 30 days after the receipt of your Appeal to review it and notify you or your representative in writing about the decision.
- Appeals are not available to beneficiaries that are not happy with the outcome of a grievance.

An **Expedited Appeal** can be requested <u>if you think waiting 30 days could seriously jeopardize your mental health or substance use disorder condition and/or your ability to attain, maintain or regain maximum function</u>. If the BHP agrees that your appeal meets the requirements for an Expedited Appeal, the BHP will resolve it within 72 hours after the Expedited Appeal is received.

Steps to file an Expedited Appeal:

- File an Expedited Appeal in person, on the phone or in writing within 60 days of the date of a Notice of Adverse Benefit Determination (NOABD). 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 calendar days from the date the NOABD was mailed or given to you.
- The BHP has 72 hours after the receipt of your Expedited Appeal to review it and notify you or your representative in a written Notice of Appeal Resolution (NAR) and may notify you verbally as well.
- If the BHP 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.

Where to File Your Appeal With Alameda County ACBHD:

By phone:	1-800-779-0787 Consumer Assistance For assistance with hearing or speaking, call 711, California Relay
Via US Mail:	2000 Embarcadero Cove, Suite 400, Oakland, CA 94606
In Person:	By visiting Consumer Assistance at Mental Health Association, 2855 Telegraph Ave, Suite 501, Berkeley, CA 94705

You have a right to a **State Fair Hearing**, an independent review conducted by the California Department of Social Services, if you have exhausted the BHP's Appeals process. A request for a State Fair Hearing is included with each Notice of Appeal Resolution (NAR); you must submit the request within 120 days of the postmark date or the day that the BHP personally gave you the NAR. You may request a State Fair Hearing whether or not you have received a NOABD. To keep your same services while waiting for a hearing, you must request the hearing within ten (10) days from the date the NAR was mailed or personally given to you or before the effective date of the change in service, whichever is later. The State must reach its decision within 90 calendar days of the date of request for Standard Hearings and for Expedited Hearings within 3 days of the date of request. The BHP shall authorize or provide the disputed services promptly within 72 hours from the date it receives notice reversing the BHP's ABD. You may request a State Fair Hearing by calling 1(800) 952-5253, or for TTY 1 (800) 952-8349, online to https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx or writing to: California 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* OR *Guide to Drug Medi-Cal Services*. For questions or assistance with filling out forms, you may ask your provider or call:

Consumer Assistance: 1(800) 779-0787

Behavioral Health Department
Alameda County Health

Karyn Tribble, PsyD, LCSW
Director

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.

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

Social Security Number ***(Required)**

I, request that my protected health information (PHI) from:

Health Care Provider Name	Telephone

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

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

I authorize the following PHI to be released from my medical record(s):

- ☐ Emergency Room Record
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Immunization Record
- ☐ Pathology Slides/Report
- ☐ Itemized Billing Records
- ☐ Discharge Summary
- ☐ History and Physical, Consultations

☐ Complete Medical Record (all pgs.) ☐ Operative Reports
☐ Other: ____

State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Mental Health Records	☐ Yes	☐ No
Psychotherapy Records	☐ Yes	☐ No
HIV Testing and Results	☐ Yes	☐ No
Alcohol, Drug, or Substance Abuse Record	☐ Yes	☐ No
Genetic Records	☐ Yes	☐ No

Covering the period of healthcare from: Specific Date(s)_________to_______
OR
☐ All past, present, and future encounters/visits

Purpose for requesting information: Resolving my grievance or appeal request

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.

____
Client or Authorized Representative Signature Date

____
Print Name Relationship to Patient (if applicable)

Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure. PROHIBITION ON RE-DISCLOSURE OF PROTECTED SUD INFORMATION: 42 CFR Part 2 prohibits unauthorized disclosure of these records.

(click here to return to relevant section of the manual)

GRIEVANCE CALL FORM

Date AND Time: *Click here to enter a date.*	**Staff:**	**Beneficiary(ACBHD)#:**

Family:(Name/Relationship)	**Authorized Representative:**	**Provider:**

Beneficiary's Name:	**Medi-Cal #:**	**MHSA Funding:** **Y or N**	

Address:	**Birthdate:**	
	Medi-Cal #:	
Phone:	**Social Security #:**	

Provider Agency: **Program Name:**	**Grievance Category:** *Choose an item.* ☐ Access: ☐ Quality of Care: ☐ Change of Provider: ☐ Confidentiality: ☐ Other:	**Time of Grievance:** *Choose an item.* **Time of Grievance Resolution:** *Click here to enter a date.*

Form of Consent: Verbal Authorization **Yes___ No ___**	**Release of Authorization Form Received: Yes ____** **No ____**

Grievance:

Grievance Resolution:

- Please fax completed form to Quality Assurance office 510-639-1346.

Behavioral Health Department
Alameda County Health
Karyn Tribble, PsyD, LCSW
Director

Letter of Acknowledgment-Appeal

Date

Name
Street
City, State, Zip

Dear Name,

This letter is to acknowledge receipt of your appeal on date, in regards services denied, terminated or modified with the Provider. If you have filed your appeal verbally, ***you are required to file it in writing as well***. The date that we have received your verbal appeal is the date we will use for timeframes as long as we receive the written appeal as well.

With the information you have provided we will investigate your appeal and inform you of a final decision within 30 calendar days. During this time you may provide verbal or written supporting documentation. I may also need to contact you to get additional information. We can arrange for an interpreter if you need one.

In order to carry out the investigation, you have been asked to consent to a limited release of confidential information. You have provided that consent verbally to me on date but not in writing. Therefore, a Release of Information form is enclosed for you to complete. Please return the form to me, along with your written statement regarding your request to appeal at: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606. You may authorize another person to act on your behalf. Non-network beneficiary representatives must complete a signed release of information form prior to Behavioral Health Care Services sharing any information.

You may not be subject to any discrimination or any other penalty for filing an appeal. You may request a copy of your appeal file and this will be provided to you free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.

If you have any questions regarding this process, please contact me at (510) xxx-xxxx.

Sincerely,

Signature block

Letter of Acknowledgment-Grievance

Date

Name
Address
City, State Zip

Dear Click or tap here to enter text.

This letter is to acknowledge receipt of your grievance on date regarding services you received from name provider. With the information you have provided we will investigate your grievance and inform you of a final decision within 90 days. During this time, you may provide additional verbal or written supporting documentation. I may also need to contact you to gather additional information. For hearing and speaking assistance, please call 711 for California Relay Service. We can also arrange for an interpreter if you need one.

In order to carry out the investigation, you have been asked to consent to a limited release of confidential information. You have provided that consent *verbally to me on xx/xx/xxxx but not in writing, therefore a Release of Information form is enclosed for you to complete and return to me.*

You may authorize another person to act on your behalf. Non-network beneficiary representatives must complete a signed release of information form prior to Behavioral Health Care Services sharing any information.

You will not be subject to any discrimination or any other penalty for filing a grievance.

If you have any questions regarding this process, please contact me at **(phone number).**

Sincerely,

Staff Name
Contact Information

Investigation Notes

Beneficiary Name: ___________________________ Date: __________________________

[ ] Spoke to person with knowledge of situation
Name:
Contact information:
Connection to matter:

[ ] Left message for person with knowledge of situation
Name:
Time of message:
Summary of message content:

[ ] Conducted site visit
Site visited:
Address:

[ ] Other

Summary of activity, action taken or conversation in support of the investigation:

Name of investigator: ____

Signature or initials: ____

Behavioral Health Department
Alameda County Health
Karyn Tribble, PsyD, LCSW
Director

NOTICE OF GRIEVANCE RESOLUTION

Date

Beneficiary Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: Your Grievance

You or *Name of requesting provider or authorized representative*, on your behalf, filed a grievance with the *Plan* on *DATE*. *Plan* has reviewed your grievance. This notice describes steps taken to resolve your grievance.

Using plain language, insert: 1. A summary of the grievance filed by the beneficiary; 2. Steps taken to resolve the grievance (e.g., investigation, speaking with provider); 3. A clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the beneficiary; and, 4. The reasons for the decision.
If you are dissatisfied with the resolution of your grievance, you may file another grievance with the Plan.

The Plan can help you with any questions you have about this notice. For help, you may call *Plan* *hours of operation* at *24/7 toll-free telephone number*. If you have trouble speaking or hearing, please call TTY/TTD number *TTY/TTD number*, between *hours of operation* for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact *Plan* by calling *telephone number*.
If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions.

You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

Signature Block

Behavioral Health Department
Alameda County Health
Karyn Tribble, PsyD, LCSW
Director

NOTICE OF APPEAL RESOLUTION-Upheld

Date

Member's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: Service requested

You or *Name of requesting provider or authorized representative*, on your behalf, appealed the *denial, delay, modification, reduction or termination or other adverse benefits determination* of *Service requested. Plan* has reviewed the appeal and has decided to uphold the decision. This request is still denied. This is because *Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity*.

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guidelines, protocol, or criteria on which we based our decision. To ask for this, please call *Plan* at *telephone number*.

You may appeal this decision by requesting a State Hearing. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send in any information that could help your case. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

The Plan can help you with any questions you have about this notice. For help, you may call *Plan hours of operation* at *Plan's Member Services telephone number*. If you have trouble speaking or hearing, please call TTY/TTD number *TTY/TTD number*, between *hours of operation* for help.

County Grievance Team

Enclosed*: "Your Rights under Medi-Cal Managed Care"*

Language Assistance Taglines

[Enclose notice with each letter]

Behavioral Health Department
Alameda County Health
Karyn Tribble, PsyD, LCSW
Director

NOTICE OF APPEAL RESOLUTION-Overturned

Date

Member's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or *Name of requesting provider or authorized representative*, on your behalf, appealed the *denial, delay, modification, or termination* of *Service requested*. *Plan* has reviewed the appeal and has decided to overturn the original decision. This request is now approved. This is because *Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity*.

Plan or Provider is required to authorize or provide you with the service within 72 hours.

The Plan can help you with any questions you have about this notice. For help, you may call *Plan hours of operation* at *Plan's Member Services telephone number*. If you have trouble speaking or hearing, please call TTY/TTD number *TTY/TTD number*, between *hours of operation* for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact *Plan* by calling *telephone number*.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

County Grievance Team

Enclosed*: "Your Rights under Medi-Cal Managed Care"*
Language Assistance Taglines

[Enclose notice with each letter]

YOUR RIGHTS UNDER MEDI-CAL

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact *Provider Name* by calling *telephone number*.

IF YOU DO NOT AGREE WITH THE DECISION MADE FOR YOUR MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT, YOU CAN FILE AN APPEAL. THIS APPEAL IS FILED WITH YOUR PLAN.

HOW TO FILE AN APPEAL

You have **60 days** from the date of this "Notice of Adverse Benefit Determination" letter to file an appeal. If your Provider Name decided to reduce, suspend or terminate treatment you are already getting, you have a right to request that the Plan continue providing that treatment while your appeal is being reviewed. This is called Aid Paid Pending. To qualify for Aid Paid Pending, you must ask your Plan for an appeal within 10 days from the date on this letter, or before the date your Plan says the services will stop, whichever is later. Even though your Plan must give you Aid Paid Pending when you ask for an appeal within these timelines above, you should let your Plan know when you ask for an appeal that you want to get Aid Paid Pending until your appeal is decided.

You will not be held liable for the cost of continued treatment if the appeal decision upholds the Plan's adverse benefit determination.

If you miss the 10-day period to request an appeal OR do not ask for an appeal before the date your Provider Name says the services will stop, you still have 60 days from the date of this Notice of Adverse Benefit Determination letter to ask for an appeal. However, you will not get Aid Paid Pending while your appeal is being decided.

You can file an appeal by phone or in writing. If you file an appeal by phone, you must follow up with a written signed appeal. The Provider Name will provide you with free assistance if you need help.

- To appeal by phone: Contact *Provider Name* between *hours of operation* by calling *telephone number*. Or, if you have trouble hearing or speaking, please call *TYY/TDD number*.

- To appeal in writing: Fill out an appeal form or write a letter to your plan and send it to:

  Provider Name
  Address
  Email and/or fax, if applicable

  Your provider will have appeal forms available. *Provider Name* can also send a form to you.

You may file an appeal yourself. Or, you can have someone like a relative, friend, advocate, provider, or attorney file the appeal for you. This person is called an "authorized representative." You can send in any type of information you want your Provider Name to review. Your appeal will be reviewed by a different provider than the person who made the first decision.

Your Provider Name has 30 days to give you an answer. At that time, you will get a "Notice of Appeal Resolution" letter. This letter will tell you what the Plan has decided. **If you do not get a letter with the Provider Name decision within 30 days, you can ask for a "State Hearing" and a judge will review your case**. Please read the section below for instructions on how to ask for a State Hearing.

EXPEDITED APPEALS

If you think waiting 30 days will hurt your health, you might be able to get an answer within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an "**expedited appeal.**"

STATE HEARING

If you filed an appeal and received a "Notice of Appeal Resolution" letter telling you that your Plan will still not provide the services, or **you never received a letter**

telling you of the decision and it has been past 30 days, you can ask for a "State Hearing" and a judge will review your case. You will not have to pay for a State Hearing.

You must ask for a State Hearing within **120 days** from the date of the "Notice of Appeal Resolution" letter. If your Provider Name continued to provide you with the disputed treatment during the Plan's appeal process, you have a right to request that the Plan continue providing that treatment until there is a decision on your State Hearing. **If you are currently getting treatment and you want to continue your treatment while your State Hearing request is being reviewed, you must ask for a State Hearing within 10 days** from the date the "Notice of Appeal Resolution" was postmarked or delivered to you. When you ask for a State Hearing, you must say that you want to keep getting your treatment. You will not be held liable for the cost of continued treatment if the State Hearing decision upholds the Provider Name adverse benefit determination. You will not have to pay for a State Hearing.

You can ask for a State Hearing by phone, electronically, or in writing:

- By phone: Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349.**

- Electronically: You may request a State Hearing online. Please visit the California Department of Social Services' website to complete the electronic form: https://acms.dss.ca.gov/acms/login.request.do

- In writing: Fill out a State Hearing form or send a letter to:

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

  Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 30 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be

able to get an answer within 3 working days. You may want to ask your provider or Plan to write a letter for you, or you can write one yourself. The letter must explain in detail how waiting for up to 30 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an **“expedited hearing”** and provide the letter with your request for a hearing.

Second Opinion

Upon your request, you have the right to a second opinion from a qualified health care professional within or outside of the network at no extra cost.

Authorized Representative

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, provider, or attorney that can speak on your behalf. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an “authorized representative.”

LEGAL HELP

You may be able to get free legal help. You may also call the local Legal Aid program in your county at 1-888-804-3536.

NON-DISCRIMINATION NOTICE

Discrimination is against the law. ACBHD follows State and Federal civil rights laws. ACBHD does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

ACBHD provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio or accessible electronic formats)
  - Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information is written in other languages

If you need these services, contact ACBHD at **Phone Number**. Or, if you cannot hear or speak well, please call **711 (California State Relay)**. Upon request, this document can be made available to you in braille, large print, audio, or accessible electronic formats.

HOW TO FILE A GRIEVANCE

If you believe that ACBHD has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Alameda County Behavioral Health Consumer Assistance. You can file a grievance by phone, in writing, or in person:

- By phone: Contact Consumer Assistance between 9am -5pm, Monday thru Friday, by calling **1-800-779-0787**. Or, if you cannot hear or speak well, please call **711 (California State Relay)**.
- In writing: Fill out a grievance form or write a letter and send it to:

Consumer Assistance
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

- In person: Visit your provider's office or the Mental Health Association, 2855 Telegraph Avenue, Suite 501, Berkeley, CA 94705, and say you want to file a grievance.
- Grievance Forms are available online, visit: *https://www.acbhcs.org/plan-administration/file-a-grievance/*.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (California State Relay)**.
- In writing: Fill out a complaint form or send a letter to:

  Department of Health Care Services Office of Civil Rights
  P.O. Box 997413, MS 0009 Sacramento, CA 95899-7413
- Complaint forms are available at: https://www.dhcs.ca.gov/discrimination-grievance-procedures
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **711(California State Relay)/TDD 1-800-537-7697**
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portalat https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Behavioral Health Department
Alameda County Health
Karyn Tribble, PsyD, LCSW
Director

NOTICE OF AVAILABILITY LANGUAGE TAGLINES

English Tagline
ATTENTION: If you need help in your language call **Phone Number** (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **Phone Number** (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **Phone Number** (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **Phone Number** (TTY: 711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **Phone Number** (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ` Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **Phone Number** (TTY: 711): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅ **Phone Number** (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **Phone Number** (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 **Phone Number** (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **Phone Number** (TTY: 711)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)
توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، (TTY: 711) **Phone Number** تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با (TTY: 711) **Phone Number** تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **Phone Number** (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **Phone Number** (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **Phone Number** (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 **Phone Number** (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は **Phone Number** (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。 **Phone Number** (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 태그라인 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 **Phone Number** (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **Phone Number** (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **Phone Number** (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສຳລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **Phone Number** (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **Phone Number** (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 **Phone Number** (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **Phone Number** (TTY:

711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ **Phone Number** (TTY: 711).
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **Phone Number** (TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **Phone Number** (TTY: 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

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

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **Phone Number** (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 **Phone Number** (TTY: 711). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **Phone Number** (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ
ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1- Phone Number** (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

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

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **Phone Number** (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 **Phone Number** (TTY: 711). Các dịch vụ này đều miễn phí.

Behavioral Health Department
Alameda County Health
Karyn Tribble, PsyD, LCSW
Director

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request-Timely Access

Date

Member's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider-Name of requesting provider has asked *Plan* to obtain or approve *Service requested*. The *Name of requesting provider* has not provided services within *number of* working days. Our records show that you requested service(s), or service(s) were requested on your behalf on *Date*.

We apologize for the delay in providing timely services. We are working on your request and will provide you with *Service requested* soon.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

The *Plan* can help you with any questions you have about this notice. For help, you may call *Plan between hours of operation* at *telephone number*. If you have trouble speaking or hearing, please call TTY/TTD number *TTY/TTD number*, between *hours of operation* for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact *Plan* by calling *telephone number*.

If the *Plan* does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

County Grievance Team

Enclosed: *Your Rights under Medi-Cal Managed Care*
Notice of Availability Language Taglines

Behavioral Health Department
Alameda County Health
Karyn Tribble, PsyD, LCSW
Director

Expedited Appeal Request: Letter of Denial

Date

Name
Address
City, State Zip

Dear Name

On date you filed an Expedited Appeal with our office regarding type text here.

You are receiving this notice because we are denying your request for an Expedited Appeal.

The California Code of Regulations, Title 9, Section 1850.208 (a) states that the Expedited Appeal process must be used when the Behavioral Health Plan (MHP) determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

We have evaluated your request and have found that your appeal does not meet these requirements.

The California Code of Regulations, Title 9, Section 1850.208(e) requires us to give prompt verbal notice of the denial of the request for an Expedited Appeal and to provide written notice within two calendar days of the date of this denial. We contacted you on date and provided you with verbal notice of the denial. This letter serves as written notice of this denial.

We will notify you of a decision on your appeal within 30 calendar days from the date we received your initial request.

Once we resolve your appeal, we will notify you and all other affected parties verbally and in writing.

If you disagree with this decision, you may file a Grievance.

This written notice is not a Notice of Action as defined in the California Code of Regulations, Section 1810.230.5.

If you have any questions, you may contact me at *insert contact information*.

Sincerely,

Signature

File Document Check List

Last Name: ________________________________ First Name: _________________________

ACBHD #: _________________________________

Staff Name Who Resolved and Credential: ____

IN ALL FILES:

_____ Documentation of Request for investigation of Grievance or Appeal from Beneficiary or Representative

_____ Authorization of Release of Information from Beneficiary

______ Letter of Acknowledgment

______ Provider Notice (Grievance/Appeal) Letter

______ Investigation Notes

______ Notice of Grievance Resolution to Beneficiary with Non-Discrimination and Language Taglines attachments.

______ Notice of Appeal Resolution to Beneficiary with Non-Discrimination, Language Tagline and NAR Your Rights attachments.

_____ Notification of Disposition (Provider)

ADDITIONAL INFORMATION:

______Supporting Documentation and additional correspondence (emails/records)

______ NOABD (if time frame exceeded) with NOABD Your rights, Non-Discrimination, and Notice of Availability Language Taglines.

______ Aid Paid Pending criteria met/Written notice sent to beneficiary (if applicable)

Appendix B: ACBHD Grievance and Appeal System Policy

Link to Policy on ACBHD Website

(click here to return to the main section of manual)

Appendix C: Other Agency Contacts

(click here to return to the main section of manual)

From time to time ACBHD may receive calls from consumers or others seeking to grieve services or an interaction with another public agency or health care provider. Below is a list of health providers, law enforcement agencies and other agencies that may serve ACBHD consumers or may be confused with ACBHD.

A. HEALTH CARE PROVIDERS

Alameda Health System Patient Affairs Office

- Contact info: Call (510) 437-4108 or drop in at the 3rd floor of A Wing at the Highland campus (M-F, 9:00am to 4:00 pm). Written compliments or grievances should be sent to: Patient Affairs Officer, Alameda Health System, 1411 E. 31st St., Oakland CA 94602.
- What to call for: Complaints about health facilities operated by AHS including Highland Hospital, John George Psychiatric Hospital, Fairmont Hospital, San Leandro Hospital, Eastmont Wellness, Hayward Wellness and Newark Wellness.

Herrick Hospital Patient Relations

- Contact Info**:** (510) 204-4689
- What to call for: Questions, concerns or complaints about a stay at Herrick Hospital medical or psychiatric units.

California Department of Public Health Licensing and Certification Program
Licensing and Certification - Complaints
Contact Info: 850 Marina Bay Parkway, Building P, 1st Floor, Richmond, CA 94804-6403
Phone: (510) 620-3900
What to call for: To submit a complaint to the Licensing and Certification Program against a health facility/provider. Complaints can also be submitted online at:

Behavioral Health Association of Alameda County
http://www.mhaac.org/
Contact info: (510) 835-5010
What to call for: Complaints from patients in psychiatric hospitals/facilities and residents of halfway houses or board and care homes who feel their rights have been denied.

LAW ENFORCEMENT

Alameda County Sheriff Internal Affairs Office (including complaints regarding Santa Rita Jail) – Citizen Complaint | Alameda County Sheriff's Office, CA
Call (510) 208-9800. Grievance forms for complaints related to Santa Rita jail can also be requested directly from jail personnel.

City of Alameda Police Department - http://alamedaca.gov/police/compliments-complaints
(510) 337-8824. Brochure with more information available on website.

Albany Police Department- http://www.albanyca.org/index.aspx?page=832#334
Call 510-525-7300 or download a complaint form at
http://www.albanyca.org/Modules/ShowDocument.aspx?documentid=24442

BART Police Department - http://www.bart.gov/about/police
Email Internal Affairs at ia@bart.gov or contact one of the following:
Call BART Police Dispatch: 510-464-7000
For non-emergency needs you can text BPD at 510-200-0992
Use this online link to communicate with police dispatch
Forms are available for download on the website

Berkeley Police Department -
http://www.ci.berkeley.ca.us/Police_Review_Commission/Home/Complaints.aspx
Police Review Commission: Calls (510) 981-4950. Forms are also available on website.

Dublin Police Department - See Alameda County Sherriff

Emeryville Police Department - http://www.ci.emeryville.ca.us/index.aspx?NID=293
Call (510) 596-3709.

Fremont Police Department - http://www.fremontpolice.org/index.aspx?NID=197
Call (510) 790-6800.

Hayward Police Department - http://user.govoutreach.com/hayward/faq.php?cid=11081
Call (510) 293-7059.

Livermore Police Department - http://www.cityoflivermore.net/citygov/police/
Call (925) 371-4900.
Newark Police Department - http://www.newark.org/departments/police/administrative-services/recruitment-and-personnel/

Call (510) 578-4237.

Oakland Police Department -
http://www2.oaklandnet.com/Government/o/CityAdministration/d/CPRB/DOWD005103

- Oakland Citizens' Police Review Board: Call (510) 238-3159. Complaints can also be filed in person at City Hall 1 Frank Ogawa Plaza, 11th Floor or online at the website above.
- Oakland Internal Affairs Division: Call (510) 238-3161 or mail a complaint form to: Oakland Police Department, Internal Affairs Division, 250 Frank Ogawa Plaza, Ste. C, Oakland, CA 94612.

Piedmont Police Department - http://www.ci.piedmont.ca.us/police/resources.shtml
Call (510) 420-3000.

Pleasanton Police Department - http://www.cityofpleasantonca.gov/pdf/citizen-complaint-english.pdf
Call (925) 931-5100.

San Leandro Police Department -
http://www.sanleandro.org/depts/pd/aslpd/contact.asp
Call 510-577-2740.

Union City Police Department - http://www.union-city.ca.us/police/support_serv.htm
To request a complaint form call (510) 471-1365.

B. VETERANS' SERVICES

Veteran's Administration Medical Services
A Patient Advocacy Program is in place at each VA health care facility to help resolve concerns about any aspect of a veteran's health care experience. Patient Advocates can be reached through the nursing or support staff in any clinical area. If a dispute cannot be resolved locally, veterans can file a complaint through the Board of Veterans' Appeals. Information on this process is at http://www.bva.va.gov/.

Alameda County Veterans Service Office (VSO) -
http://www.alamedasocialservices.org/public/services/veterans_services/index.cfm

- Contact info:
    - Oakland (Main Office), 6955 Foothill Blvd., Ste. 300
      (510) 577-1926
    - Hayward, 24100 Amador St.

(510) 265-8271
  - Fremont, 39155 Liberty St., Ste. F620
    (510) 795-2686

- What to call for: Provides veterans and their dependents and/or survivors with information regarding veteran's benefits, and assistance with filing benefit claims, waivers and appeals.

Officer of Inspector General Hotline

- Contact info: **(800) 488-8244 or** vaoighotline@va.gov
- What to call for: Complaints regarding criminal activity, fraud, waste, abuse and mismanagement of VA programs and operations.

C. RESIDENTIAL FACILITIES AND HOUSING

Behavioral Health Care Services Housing Services Office can take complaints related to shelters and assist consumers who face a housing crisis.
Housing Services Office
2000 Embarcadero Cove, STE 400 - # 12
510-567-8146

East Bay Delta Adult and Senior Care Regional Office

- Contact info: 1515 Clay Street, Suite 310, MS 29-21, Oakland, CA 94612
  Telephone: (510) 286-4355
- What to call for: Complaints about Residential Care Facilities for the Elderly, Adult Residential Facilities (including Board and Care homes), Adult Day Programs, or Social Rehabilitation Facilities.

ECHO Housing

- Contact info:
  Northern Alameda County, call 510-496-0496
  Southern Alameda County, call 510-581-9380
  Tri-Valley Area, call 925-449-7340
- What to call for: Information on Fair Housing Laws and Illegal Housing Discrimination

Homeless Shelters

Agencies who operate emergency shelters each have individual agency grievance processes that clients should utilize for complaints. 211 can provide contact information for shelters.

US Department of Housing and Urban Development

- Contact info:
  San Francisco Regional office, call 800-347-3739
  Or online at
  http://portal.hud.gov/hudportal/HUD?src=/topics/housing_discrimination
- What to call for: To make a formal complaint about discrimination in housing.

Rent Review Boards

Some East Bay cities set limits on the amount by which the rent can rise and/or offer review or mediation services to tenants who believe they have had their rent increased unfairly.

City of Alameda Rent Review Advisory Committee
(510) 747-4316
http://www.alamedahsg.org/hd_hsg_rrac.html

Alameda County Rent Review Program (for unincorporated county including San Lorenzo, Castro Valley, Ashland and Cherryland)
224 W. Winton Ave., Room 108, Hayward, CA 94544
(510) 670-6682
http://www.acgov.org/cda/hcd/rent.htm

Berkeley Rent Stabilization Board
2125 Milvia Street, Berkeley, CA 94704
(510) 981-7368
http://www.ci.berkeley.ca.us/DepartmentHome.aspx?id=9546

Fremont Housing and Redevelopment Department
39550 Liberty St. First Floor, Fremont, CA 94538
510-494-4500
http://www.fremont.gov/index.aspx?NID=422

Hayward Rent Control Information
777 B Street, Hayward, CA 94541
(510) 583-4454
https://www.hayward-ca.gov/residents/housing

Oakland Rent Adjustment Program
250 Frank H. Ogawa Plaza, 6th Floor, Oakland, CA 94612
(510) 238-3721
http://www2.oaklandnet.com/Government/o/hcd/s/RenterResources/index.htm

San Leandro Rent Review Program
(510) 581-9380 (operated by ECHO Housing)
https://www.sanleandro.org/depts/cd/housing/rentreview/default.asp

D. OTHER ASSISTANCE ORGANIZATIONS

Mental Health Advocates
http://www.mhaac.org/behavioral-health-advocates.html

- Contact info: 510-835-5532 or drop in Monday - Friday 9am-5pm at 2855 Telegraph Avenue, Suite 501, Berkeley, CA 94705
- What to call for: Assistance with problems with SSI benefits or help acquiring behavioral health and other services, financial aid or benefits.

Families Information and Referral Service Telephone (FIRST)
http://www.mhaac.org/family-caregiver-advocate.html

- Contact info: (510) 835-0188.
- What to call for: FIRST is a central source of information, referral and advice for anyone in Alameda County who is trying to help a relative or friend with behavioral illness. FIRST provides information on the behavioral health system and law, referral to public and private services, and advice and help in sorting out options and making informed decisions.

Appendix D: Legal Rights of Patients and Tenants

(click here to return to the main section of manual)

A. Patients' Rights

Patients' rights are different from the right beneficiaries of County-funded behavioral health services have to grieve or appeal the actions of the County or its contractors. Generally, when the service or treatment was provided in an in-patient setting, and particularly on an involuntary hold, the applicable process is Patient's Rights. The section below describes some of the key rights that consumers have as patients and how to know when an action may raise a patient's rights issue.

To reach a Patients' Rights Advocate call 800-734-2504 or if outside the county, dial 510-835-2505

1. Involuntary Detention

Under Welfare and Institutions Code (WIC) 5150 a person may be involuntarily taken to a behavioral health facility for psychiatric evaluation for up to 72 hours. A person can be involuntarily detained if they meet one of the following criteria due to a behavioral illness:

1. The person presents a danger to him/herself.
2. The person presents a danger to others.
3. The person is incapacitated to the point of being gravely disabled. That means the person cannot provide for their own food, clothing, and/or shelter, or cannot make use of the food, clothing, and shelter available to him/her.

After the 72-hour evaluation period, a psychiatrist may petition to continue involuntary treatment for up to an additional 14 days. The psychiatrist must file a "5250" or "certification for up to fourteen days of intensive psychiatric treatment" with superior court. The client is then entitled to an automatic hearing and a Patients' Rights advocate from the Patients' Rights Advocacy office represents the client. Upon conclusion of a 14-day hold, if the doctor still believes the client is gravely disabled, the doctor may file for "temporary conservatorship". This legal hold can last up to 30 days (unless it is agreed by the court that it may be longer, or "continuous", for specific legal reasons). If the person objects, a writ of habeas corpus can be filed. Hospital staff are obligated by law to assist any clients who requests assistance to file a request to the public defender's office for a writ of habeas corpus.

2. Conservatorship

Upon expiration of a temporary conservatorship, the doctor may file a petition for a permanent conservatorship with the court if a person is still considered gravely disabled. LPS conservatorship, once granted by a judge at a hearing, lasts up to one year. The conservator may be a private citizen or someone from the public guardian's office. If conservatorship is granted, the person may request a reconsideration hearing with a public defender. If the request for release at the reconsideration hearing is not granted the person may have another such hearing six months later. (There are other legal vehicles through which a person may challenge conservatorship such as appeals and writs of habeas corpus.)

3. Antipsychotic Medication

Psychiatric patients, whether voluntary or involuntary, must give informed consent prior to receiving treatment with antipsychotic medications. Both voluntary and involuntary patients have the right to refuse medication. The exceptions to this are emergency administration of medications or a court determination of a patient's lack of capacity to give informed consent and/or refuse antipsychotic medications. A doctor may file a petition to the court for permission to administer antipsychotic medications to involuntary patients over their objections. A capacity hearing is held, and the patient is entitled to representation by a Patients' Rights Advocate. The patient can file for an appeal to take the case before superior court should they wish to dispute the findings of this hearing.

Patients on conservatorship should have a determination regarding capacity to refuse medications as part of the conservatorship orders. Patients on conservatorship who wish to appeal court or conservatorship decisions should be encouraged to contact the Patients' Rights Advocacy Office for assistance.

4. Patients' Rights while Hospitalized

While in the hospital, patients are provided with certain rights by law as specified in WIC 5325 and 5325.1. These rights can be denied in certain circumstances for good cause with a written order from a doctor. These rights include:

1. The right to wear one's own clothes.
2. The right to keep and use one's own personal belongings.
3. The right to keep and spend a small amount of one's own money for canteen expenses and small purchases.
4. The right to see visitors each day.

5. The right to have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them.
6. To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.
7. The right to refuse any type of convulsive treatment.
8. The right to refuse any type of psychosurgery in which brain tissue is destroyed.
9. The right to see and receive the services of a patients' rights advocate who has no direct or indirect clinical or administrative responsibility for the person receiving behavioral health services.
10. The right to receive materials notifying each person of his or her rights within 24 hours of admission to a facility in a language or modality in which the person may comprehend.

Additional rights include:
1. The right to religious freedom and practice.
2. The right to participate in appropriate programs of publicly supported education.
3. The right to physical exercise and recreational opportunities.
4. The right to be free from hazardous procedures
5. The right to have one's record remain confidential (there are exceptions specified in the legislature).
6. The right to not be discriminated against for filing a complaint.
7. The right to have the same legal rights and responsibilities guaranteed all other persons unless specifically limited by federal or state laws or regulations.

B. Housing Rights and Reasonable Accommodation

Landlords are prohibited by federal and state law from engaging in behavior that is discriminatory. The California Fair Employment & Housing Act (FEHA) prohibits discrimination in housing based on a person's race, religion, national origin, color, sex, marital status, ancestry, family status, disability, sexual orientation, and source of income. Violations of fair housing law include refusing to rent to someone or offering inferior facilities or inferior lease terms to members of a protected class, segregating certain people to certain areas of a building or treating certain tenants differently because they are members of a protected class.

Not only does the law prohibit landlords from discriminating against people with disabilities, but the law also says that if certain modifications or exceptions need to be made in order for a person with a disability to get or keep housing then they may be required. By law, landlords are required to “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability.”

There are three different types of accommodations that can be requested: physical accommodations, changes to how information is shared and exceptions to rules. It is the responsibility of the tenant or potential tenant to request an accommodation. In order to deny a request, a landlord must demonstrate that the accommodation would pose an undue financial or administrative burden. If the housing is run by a nonprofit organization and includes the provision of supportive services, a landlord is not obligated to make a change that would fund behaviorally alter the nature of the program. For example, if the housing has on-site case management services but does not provide transportation assistance, the landlord would not be required to assist a disabled tenant to get to the grocery store. Housing providers who receive public funds may be obligated to bear reasonable costs for modifications. Private landlords are not obligated to bear costs for accommodation and may require that tenants pay for any modifications that they request and also that they return the unit to its original state when they move out.

While the request for accommodation does not have to be in writing, it is always preferable that the request be made in writing so that there is a record of it in case the landlord turns down the request or doesn't follow through with what they agreed to. The landlord is allowed to ask a tenant to provide evidence that they have a disability (such as a doctor's note or evidence that they receive SSI) and to show the relationship between the disability and the requested accommodation. They are not allowed to ask for additional information about the nature of the disability that does not relate to the request.

Note that even when a building has a No Pet Policy, it must still allow companion or service animals as a reasonable accommodation for tenants with a disability who request exception to the No Pet Policy. A tenant requesting such an exception must demonstrate that the animal is necessary for coping with the tenant's disability and for the tenant to be able to enjoy the full benefits of the housing being provided. The landlord may request documentation of the need for the animal from a health care provider and can require that the tenant abide by rules such as properly caring for the animal and keeping the animal leashed in common areas.

C. Other Resources

For information about rights of residents in Board and Care Homes, visit:
http://www.disabilityrightsca.org/pubs/502501.htm

For information about behavioral health rights of county jail inmates, visit:
http://www.disabilityrightsca.org/pubs/518101.htm

For information about accessing In Home Support and Services Program (IHSS,) visit:
http://www.disabilityrightsca.org/pubs/PublicationsIHSSNutsandBolts.htm

For information about denial or reduction of IHSS, visit:
http://www.disabilityrightsca.org/pubs/547001-Ch-08.pdf

Appendix E: Code of Regulations

DHCS Information Notice No.: 25-014

Link to DHCS Information Notice 25-014

(click here to return to the main section of manual)