Behavioral Health Department
Alameda County Health

# 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*:**

Behavioral Health

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.**

Behavioral Health

## What is the problem?

## What have you done to try to resolve the problem?

## What would you like the solution to be?

Behavioral Health

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.***