ALPINE COUNTY BEHAVIORAL HEALTH SERVICES
75 C DIAMOND VALLEY ROAD
MARKLEEVILLE, CA 96120

(530) 694-1816
(530) 694-2387 (FAX)
(800) 318-8212

Problem Resolution Process

If you have a suggestion, grievance or wish to file an appeal, please complete the reverse side of this form. You may ask your therapist or the Patient's Rights Advocate (call 223-6412 for contact information) for assistance in this process. Interpreter services are available if needed.

You may choose to present the suggestion, grievance or appeal orally or in writing. Oral appeals must be followed up in writing to be considered. You may use the following methods for filing:

- Complete the reverse side of this form and give to receptionist or your therapist, put in the suggestion box, or mail in the addressed envelopes provided.
- Call the clinic and say that you would like to file a grievance or begin the appeal process.
- Come in to the clinic and say that you would like to file a grievance or begin the appeal process.

There is no penalty for filing a grievance or an appeal and you may continue to receive services during this process. You will not be discriminated against for filing a grievance or appeal.

Grievances are filed when there is dissatisfaction regarding any matter other than an action. You will receive a response within 30 days.

An action means that if you are upset about a limitation, denial or reduction of services, you may file an appeal. You will receive a response within 45 days. Expedited appeals may be requested. If circumstances meet the expedited appeal requirements, you will receive a response within 3 days.

You may authorize another person to act on your behalf in this process.

You may request a State Fair Hearing if not satisfied with the appeal process.
Contact: California Department of Social Services
State Hearings Division
PO Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
You may call (800) 952-5253 to ask for a hearing. If you are deaf and use TDD, call (800) 952-8349.
Please see reverse side of this form.

Please check one of the following:

Suggestion ☐ **Grievance ☐** **Appeal ☐** **Expedited Appeal ☐**

Name_____ Date_____ DOB_____

Phone_____ Address_____

Describe the issue: (please include dates and names if possible)

What has been done to try and resolve this issue?

What are your suggestions to help us improve?

Signature of Client or Guardian_____

Name of client representative in this process if applicable:_____

Signature of Client Representative if applicable_____

Thank you for submitting this information to Alpine County Behavioral Health Services.