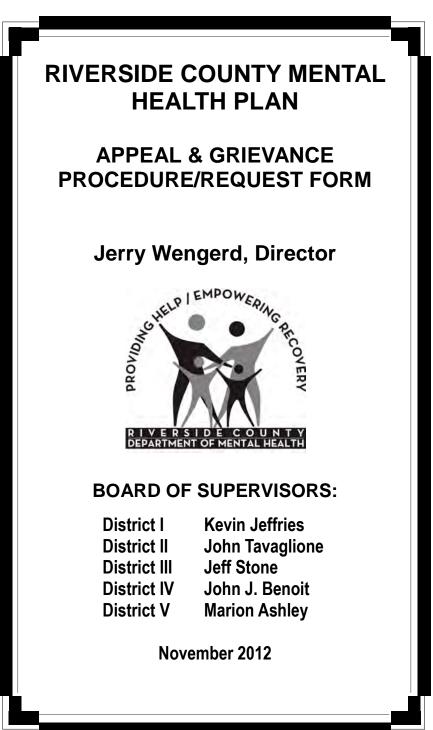
To obtain information on the status of a pending appeal or grievance, contact the Quality Improvement Coordinator at (800) 660-3570.

## **State Fair Hearings**

Medi-Cal consumers may have any of their concerns addressed at any State Fair Hearing after completion of the Appeals/Grievance process. If you file a hearing within ten (10) days of a Notice of Action that your mental health services are being denied, reduced or terminated, there are circumstances where the services can be continued until the hearing. A Request for a State Fair Hearing Form is included with each Notice of Action to deny, reduce or terminate services. You may also request a State Hearing by calling the State Fair Department of Social Services at (800) 952-5253.

#### www.rcdmh.org



## RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH APPEAL & GRIEVANCE PROCEDURE

A consumer and/or consumer's representative may file an appeal, orally or in writing, with his/her service provider, the C.A.R.E.S. Team, or the Quality Improvement Program.

An **Appeal** is a request for a review of an action by the authorization unit C.A.R.E.S. Team or the RCDMH Program. An action is defined as the modification or denial of a requested service from a consumer and/or a reduction, suspension, or termination of a previously authorized service.

A **Grievance** is defined as an expression of dissatisfaction concerning services received from the Mental Health Plan. Examples of grievances might be as follows: the quality of care or services provided, aspects of interpersonal relationships - such as rudeness of an employee, etc.

Enclosed, is an Appeal/Grievance Request Form for the consumer and/or consumer's representative to use to file a written Appeal or Grievance. If you need assistance in completing the form, you can request help from your provider, or by calling the Quality Improvement Program at (800) 660-3570, or Patients' Rights at (800) 350-0519, or locally (951) 358-4600.

The Appeal/Grievance Request Form can be submitted to your provider, the program supervisor, the C.A.R.E.S. Team, or mailed directly to Quality Improvement in the selfaddressed envelope available in your provider's lobby or reception area.

### You will not be subject to discrimination or any other penalty for filing an Appeal or Grievance.

For Appeals Only: Please indicate if the consumer is in any Medi-Cal funded residential treatment program. The Expedited Appeals block should be checked on the Appeal/Grievance Request Form when taking the time for a standard resolution of an appeal could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

Medi-Cal beneficiaries may file for a State Fair Hearing after the completion of the Appeal or Grievance process.

Riverside County Mental Health Plan	For Office Use Only:	
<b>Quality Improvement Coordinator</b>	By: Forward to:	
P.O. Box 7549	Date:	
Riverside, CA 92513	Date Consumer Notified:	
1-800-660-3570	Outcome:	

# **APPEAL/GRIEVANCE REQUEST**

This form is used to file an Appeal Request. If you need assistance in completing this form, you can request help from your provider, or calling the Quality Improvement Program at (800) 660-3570 or Patients' Rights at (800) 350-0519, or locally, (951) 358-4600. A signed Release of Information Form needs to be submitted with this appeal request. The appeal request can be submitted to your clinician, the Program Supervisor, or mailed directly to the Quality Improvement Program at the address shown above.

#### 

## PLEASE PRINT

Your address and phone number are important. We need this information to contact you about the outcome of your Appeal or Grievance.

Your Name:	 
Your Address:	
Your Daytime Phone:	

□ Check here if you are currently a resident of a Medi-Cal funded residential treatment program.

□ Check here if you are requesting that your appeal request be processed through the Expedited Appeals Process

Current Provider:

If Applicable, Person Representing You:

Their Address: \_\_\_\_\_

Their Daytime Phone: \_\_\_\_\_

What is the problem?		
What would you like the solution to be?		
Whom have you talked to about the problem?		

**Client (or Client's Representative) Signature** 

Date

You will not be subject to discrimination or any other penalty for filing an Appeal or Grievance. 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 Appeals or Grievance Process.

## **Riverside County Mental Health Plan Authorization for Release of Information from the Medical Record**

Client's I	Last Name	First Name	Middle Name	Date of Birth	
Street Ad	dress	City	Zip Code	Telephone Number	
I, the und with reco	U	y authorize (Name	and address of hea	Ith care service provider	
Health Ca	are Provider N	lame			
Street Ad	dress				
City		Sta	ate	Zip Code	
And to:		-	alth Plan		
	•	cords for the purpo to provide such cop		y be requested.	
The authors	prization is sul	oject to the followi	ng limitations:		
□ 1.	Confined to records regarding treatment for the period from				
			_ to	·	

□ 2. Confined to records regarding admission and treatment for the following

	medical condition or injury:
3.	Confined to the following specified information:
4.	All medical records.

This consent is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance hereon, and if not earlier revoked, it shall terminate three (3) months from the date of consent without express revocation.

Signature of Client, Legal Guardian, Representative (Please Circle)

Date

Signature of Witness

Date

Any disclosure of medical records information by the recipient(s) is prohibited except when implicit in the purpose of the disclosure.