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 Fair Hearing by calling the State Department of Social Services at (800) 952-5253.

www.rcdmh.org

RIVERSIDE COUNTY MENTAL HEALTH PLAN

APPEAL & GRIEVANCE PROCEDURE/REQUEST FORM

Jerry Wengerd, Director

BOARD OF SUPERVISORS:

District I	Kevin Jeffries
District II	John Tavaglione
District III	Jeff Stone
District IV	John J. Benoit
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November 2012

QA 114 (Rev 11/12)

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 self-addressed 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
Quality Improvement Coordinator
P.O. Box 7549
Riverside, CA 92513
1-800-660-3570

For Office Use Only:
By: _________ **Forward to:** _________
Date: ______________________________
Date Consumer Notified: ___________
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.

I wish to file: ☐ **Appeal** ☐ **Grievance**

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 Last Name First Name Middle Name Date of Birth

____
Street Address City Zip Code Telephone Number

===

I, the undersigned, herby authorize (Name and address of health care service provider with records.)

____
Health Care Provider Name

____
Street Address

____
City State Zip Code

And to: **Riverside County Mental Health Plan**
Quality Improvement (QI)
P.O. Box 7549
Riverside, CA 92513

access to my medical records for the purpose of _______________________________.
I further authorize you to provide such copies thereof as may be requested.

The authorization is subject to the following 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.