



Member Grievance Appeal Process and Form

Sonoma County Behavioral Health Division (BHD) Members have rights.
These rights include reporting issues about services received.
If you would like to report an issue, please complete the form below.

Return completed form to the receptionist
or

Mail to:
Sonoma County Behavioral Health Division
C/O Grievance Coordinator
2227 Capricorn Way
Santa Rosa CA 95407-5419

Phone: 707-565-7895 or 1-800-870-8786, TTY: 711

MEMBER RIGHTS

As a member of Sonoma County BHD, you are entitled to:

- Be treated with dignity, respect and the utmost consideration for your privacy;
- Services provided in a safe environment;
- Request free interpreter services;
- Receive information on treatment options and alternatives, presented in a language and format you can understand;
- Request a change of provider, a second opinion, or a change in level of care;
- Participate in decisions regarding your health care, including the right to refuse treatment;
- Request and receive a copy of your medical records upon request (costs may apply) and ask that they be amended;
- Authorize a person to act on your behalf during the grievance, appeals, or State Hearing process;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- File a grievance, and BHD members with Medi-Cal can file an appeal, expedited appeal, or a request for a State Hearing without retaliation.

SONOMA COUNTY BEHAVIORAL HEALTH DIVISION GRIEVANCE	APPEALING A NOTICE OF ADVERSE BENEFIT DETERMINATION
<p>BHD is committed to finding solutions to the issues you may encounter when receiving behavioral health services. BHD will not discriminate against, or treat unfairly any person who files a grievance, appeal, or expedited appeal.</p> <p>Grievances and appeals can be filed verbally, or in writing to the Grievance Coordinator. Individuals who choose to file a grievance will have the opportunity to present information at any time during the resolution process. Anyone can file a grievance, but appeals and expedited appeals are only available to BHD Medi-Cal members. For questions or assistance with filing a grievance, or an appeal, please call:</p> <p style="text-align: center;">BHD Grievance Coordinator Phone: 707-565-7895 or 1-800-870-8786 TTY: 711</p> <p>Information and form are located at: http://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/</p> <p style="text-align: center;">FILING A GRIEVANCE</p> <p>Grievance filers are encouraged (but not required) to discuss their grievance with BHD staff or an agency representative. If after speaking with staff the grievance filer remains unsatisfied with the provided resolution, they have the right to pursue the unresolved grievance with the BHD Grievance Coordinator.</p> <p>If the grievance remains unresolved by the end of the following business day, the Grievance Coordinator will send an acknowledgement letter to the grievance filer within 5 calendar days from the date of the grievance initiation.</p> <p>Within 30 calendar days, BHD will review and investigate the grievance, and a written Notice of Grievance Resolution (NGR) will be provided to the grievance filer, or their authorized representative.</p>	<p>BHD Medi-Cal members have the right to file an appeal within 60 calendar days of the Notice of Adverse Benefit Determination (NOABD) issuance.</p> <p>NOABDs are issued when BHD does any of the following: denies, reduces, suspends or terminates services; denies payments for services; fails to provide services in a timely manner; fails to resolve grievances/appeals in a timely manner; or denies a member's request to dispute financial liability.</p> <p>Appeals can be filed verbally or in writing. However, after making a verbal appeal, a written appeal must be submitted to BHD by the member, or their authorized representative.</p> <p>A written acknowledgement of the appeal will be sent to the member within 5 calendar days of receipt.</p> <p>The appeal will be reviewed and a written Notice of Appeal Resolution (NAR) will be provided to the member within 30 calendar days of the appeal receipt.</p> <p>Notice of extensions will be provided to the member within 2 calendar days of the decision to extend the timeframe, under certain circumstances. For any extensions that were not requested by the member, BHD will provide the member with a written reason for delay.</p>

<p align="center">APPEALING A NOTICE OF ADVERSE BENEFIT DETERMINATION (continued)</p>	<p>When performing <i>Standard Hearings</i>, the State must reach its decision on the hearing within 90 calendar days of the date of the request for the hearing.</p>
<p><i>Expedited Appeal:</i> An expedited appeal may be requested if the member or their provider decides that a standard appeal could seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum functioning.</p> <p>A request for an expedited appeal can be filed verbally. The expedited appeal will be reviewed and a written response will be provided to the member no later than 72 hours after receipt.</p>	<p>When performing <i>Expedited Hearings</i>, the State must reach its decision on the hearing within 3 working days of the date of the request for the hearing.</p> <p>To request a State Hearing, call State Hearing Division in Sacramento:</p> <p align="center">PHONE: 1-800-952-5253 TDD: 1-800-952-8349</p>
<p align="center">FILING A STATE HEARING</p>	<p align="center">NOTICE TO MEMBERS</p>
<p>BHD Medi-Cal members have the right to request a State Hearing. Members must exhaust the BHD appeal process prior to requesting a State Hearing.</p> <p>Members may request a State Hearing in response to receiving a NAR concerning the outcome of a NOABD. Or if BHD fails to adhere to NOABD or NAR issuance timeframes.</p> <p>The member has 120 calendar days from the NAR date to request a State Hearing. If the member files for a State Hearing within 10 calendar days of the receipt of a NOABD, under certain circumstances, the existing level of services may be maintained pending the outcome of the hearing.</p>	<p>The Board of Behavioral Sciences (BBS) receives and responds to complaints regarding services provided by marriage and family therapists, licensed educational psychologists, clinical social workers, and professional clinical counselors.</p> <p>In addition to filing a grievance with BHD, you may file a complaint directly with the BBS by contacting the board online at www.bbs.ca.gov or by calling (916) 574-7830.</p>

GRIEVANCE / APPEAL / EXPEDITED APPEAL FORM

Today's Date: _____ ☐ Grievance ☐ Appeal ☐ Expedited Appeal

Name of Member: _____ Birthdate: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Email: _____

Name of legal guardian/conservator: _____

Name of services provider: _____

Person filing: _____ Phone: _____

Do you have Medi-Cal? Y ☐ N ☐

Optional: I authorize the following person to act on my behalf in pursuing this grievance or appeal*

Name: _____ Relationship to
MEMBER: _____

** Authorization for Release of Protected Health Information (MHS 102) required.*

**PLEASE PRINT CLEARLY. BE SPECIFIC BY GIVING NAMES, DATES, AND TIMES
WHENEVER POSSIBLE. (Attach additional sheets if needed)**

1. Please describe the issue.

2. Please explain how you have tried to resolve the issue.

3. What would you consider a proper solution to this issue?

Return completed form to the receptionist or

Mail to: Grievance Coordinator
2227 Capricorn Way, Santa Rosa, CA 95407-5419
Phone: (707) 565-7895 TTY: 711

Staff Use Only: ☐ Exempt: Grievance resolved by end of the next business day following the date of receipt.
☐ Non-Exempt: Grievance not resolved by end of the next business day following the date of receipt.

NOTE: Forward all Exempt and Non-Exempt Grievances immediately to Grievance Coordinator.



NONDISCRIMINATION NOTICE

Discrimination is against the law. Sonoma County follows State and Federal civil rights laws. Sonoma County 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.

Sonoma County 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 written in other languages

If you need these services, contact Sonoma County between 8:00am-5:00pm by calling 1-707-565-7895. Or, if you cannot hear or speak well, please call 1-800-735-2929 or 711. 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 Sonoma County 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 BHD Grievance Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact BHD Grievance Coordinator between 8:00am-5:00pm by calling 707-565-7895. Or, if you cannot hear or speak well, please call 1-800-735-2929 or 711.
- **In writing:** Fill out a complaint form or write a letter and send it to:
BHD Grievance Coordinator
2227 Capricorn Way
Santa Rosa, CA 95407-5419
- **In person:** Visit your doctor's office or BHD and say you want to file a grievance.
- **Electronically:** Visit Sonoma County BHD website at
<https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials>

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 **TTY/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 Portal at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>



Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

ATTENTION: If you need help in your language call 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-870-8786 or 1-707-565-6900 (TTY: 711). These services are free of charge.

العربية (Arabic)

1-800-870-8786 or 1-707-565-6900 یرج الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكباري. اتصل بـ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). هذه الخدمات مجانية.

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-870-8786 or 1-707-565-6900 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-870-8786 or 1-707-565-6900 (TTY: 711): Այդ ծառայություններն անվճար են:

ខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-870-8786 or 1-707-565-6900 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរព្រម ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-870-8786 or 1-707-565-6900 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

繁體中文 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-800-870-8786 or 1-707-565-6900 (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 1-800-870-8786 or 1-707-565-6900 (TTY: 711)。这些服务都是免费的。

فارسی (Farsi)

تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-870-8786 or 1-707-565-6900 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-870-8786 or 1-707-565-6900 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-870-8786 or 1-707-565-6900 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-870-8786 or 1-707-565-6900 (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 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語 (Japanese)

注意日本語での対応が必要な場合は 1-800-870-8786 or 1-707-565-6900 (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。1-800-870-8786 or 1-707-565-6900 (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 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-870-8786 or 1-707-565-6900 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-870-8786 or 1-707-565-6900 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໃບທາດປີ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໃບທາດປີ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-870-8786 or 1-707-565-6900 (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 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-870-8786 or 1-707-565-6900 (TTY: 711). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-870-8786 or 1-707-565-6900 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-870-8786 or 1-707-565-6900 (линия TTY: 711). Такие услуги предоставляются бесплатно.

Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-870-8786 or 1-707-565-6900 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Estos servicios son gratuitos.

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-870-8786 or 1-707-565-6900 (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 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Libre ang mga serbisyonang ito.

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-870-8786 or 1-707-565-6900 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-870-8786 or 1-707-565-6900 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้.

Українська (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-870-8786 or 1-707-565-6900 (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 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-870-8786 or 1-707-565-6900 (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 1-800-870-8786 or 1-707-565-6900 (TTY: 711). Các dịch vụ này đều miễn phí.