COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
COMPLAINT / GRIEVANCE / APPEAL FORM

Mail: Substance Abuse Prevention and Control
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhamabra, CA 91803
To check submission status call: (XXX) XXX-XXXX

Website: http://publichealth.lacounty.gov/sapc/
Fax: (XXX) XXX-XXXX

1. (Check one): ☐ Complaint / Grievance ☐ Expedited Appeal ☐ Standard Appeal	2. Submission Date:	3. Reference Number:

PATIENT INFORMATION

4. Name (Last, First, and Middle)	5. Date of Birth (MM/DD/YY):	6. Medi-Cal Identification Number:
7. Address:		8. Phone Number:
9. Gender	10. Preferred Language / 11. Race/Ethnicity (Optional)	Okay to Leave a Message? ☐ Yes ☐ No

INFORMATION OF PATIENT REPRESENTATIVE (IF APPLICABLE)

12. Name:	13. Relationship:	14. Patient's Phone Number:
15. Address:		Okay to Leave a Message? ☐ Yes ☐ No

16. If the patient authorizes the above named person/entity to represent him/her, patient signs here:

PROVIDER AGENCY WHERE ISSUE OCCURRED

17. Provider Agency Name:	18. Contact Person:	19. Phone Number:
20. Address:		21. Fax Number:

INFORMATION ABOUT YOUR COMPLAINT / GRIEVANCE / APPEAL

22. Please describe the nature of the issue. Include any important information about the incident, such as the date, person(s) involved, etc. Attach sheets, if needed.

23. Please explain how you have tried to resolve this issue and your proposed resolution. Include any information on whether you have contacted the above mentioned provider agency, the date you contacted the agency, the name(s) you spoke with, the outcome, etc.

24. Signature:	25. Date:

INTERNAL SAPC USE ONLY

☐ Approved ☐ Denied ☐ Refer to Medical Director/Designee

Comments:

Reviewed by: Date:

Medical Director /Designee Decision: ☐ Approved ☐ Denied

Comments:

Medical Director/Designee Signature: Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Client Name: Medi-Cal ID:

Treatment Agency:

COMPLIANT / GRIEVANCE / APPEAL FORM AND AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

THE PURPOSE OF A COMPLAINT / GRIEVANCE / APPEAL

A complaint/grievance or appeal is a procedure for resolving a problem. It is a dissatisfaction made by you, your representative, or your provider on your behalf regarding an experience with the Los Angeles County Substance Abuse Prevention and Control and/or its contracted provider.

YOUR RIGHTS

- If you sign this form, you give consent to release health information, as stated below under the section AUTHORIZATION TO RELEASE HEALTH INFORMATION FORM.
- You do not have to sign this form. Your refusal will not affect your ability to obtain treatment.
- You shall be treated with respect and with due consideration for your dignity and privacy.
- You can revoke or cancel your authorization to allow use of your health information at any time by submitting a written notice to Los Angeles County Department of Public Health, Substance Abuse Prevention and Control (SAPC). You must sign your revocation request and address your fax or mail to:

  Substance Abuse Prevention and Control
  1000 S. Fremont Ave., Bldg. A9 East, 3rd Floor
  Alhambra, CA 91803
  FAX: (626) 299-4390

  Revocations may also be submitted via SAPC Website:
  http://publichealth.lacounty.gov/sapc/

- If you revoke this Authorization to release your health information, we may still use and share our health information that has already been obtained for reasons related to prior reliance of this Authorization.
- If you sign this form, you must be provided with a signed copy of this form.

THE COMPLAINT / GRIEVANCE OR APPEAL PROCESS

If your right(s) have been violated or you are dissatisfied with any aspect of your treatment, you may file a complaint/grievance and/or appeal. Please complete the attached form and include a description of your situation and dissatisfaction, and submit the form as indicated above. The SAPC will send an acknowledgement letter to the patient and/or his/her representative according to the timeframes outlined in the table below.

Description	Receipt Notification	Decision Notification	Written Decision Notification
Complaint/Grievance	Within three (3) calendar days of receipt of complaint/grievance	Within seven (7) calendar days of receipt of complaint/grievance	Within thirty (30) calendar days of receipt of complaint/grievance
Expedited Appeal for Initial Residential Authorizations and Medication-Assisted Treatment for Youth under 18.	Within two (2) business days of appeal	If a request for expedited resolution of an appeal is denied, it is transferred to the timeframe for standard resolution and reasonable efforts to provide the patient prompt oral notice of the denial	Within two (2) business days of receipt of appeal request
		Within three (3) business days of receipt of appeal	Within seven (7) business days of receipt of appeal request
Standard Appeal for Residential Reauthorizations, Grievance Decisions, etc.	Within three (3) calendar days of appeal	Within twenty-one (21) calendar days of receipt of appeal	Within forty-five (45) calendar days of receipt of appeal request

After you have completed the SAPC appeal process, you may request a State Fair Hearing by submitting a written request within sixty (60) days of the written notice of denial to:

Department of Social Services
State Hearing Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

Telephone: 1 (800) 952-5253
TDD: 1 (800) 952-8349

The provider shall continue treatment services pending a fair hearing decision only if you appeal in writing for a hearing within 10 calendar days of the mailing or personal delivery of the written notice of denial.

AUTHORIZATION TO RELEASE HEALTH INFORMATION FORM

Authorization Approval: By signing this form, I give permission to the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control program to investigate my complaint/grievance, or appeal. This authorization will allow my substance use disorder treatment providers to disclose my past and current treatment and medical information, and any other information relating to my grievance or appeal. This authorization will expire on the date of the resolution of my complaint/grievance or appeal.

Signature of Patient/Patient Representative

Date

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Client Name:

Medi-Cal ID:

Treatment Agency:

COMPLAINT / GRIEVANCE / APPEAL FORM INSTRUCTIONS

1. Check the appropriate box for what is being submitted: a complaint/grievance, expedited appeal, or standard appeal.
2. Enter the submission date of the complaint/grievance, or appeal.
3. Reference number will be assigned at the time of the receipt of the form.

PATIENT INFORMATION

4. Enter the patient's name in the order of last name, first name, and middle name.
5. Enter the patient's date of birth.
6. Enter the patient's Medi-Cal number. If the number is not known, leave the space blank.
7. Enter the patient's address.
8. Enter the patient's phone number. Check box to indicate if it is okay to leave a message at this phone number.
9. Enter the patient's gender.
10. Enter the patient's preferred language
11. Enter the patient's race/ethnicity (optional).

INFORMATION OF PATIENT REPRESENTATIVE (IF APPLICABLE)

12. Enter the name of the patient's representative if applicable. It can be an individual or an entity. If the patient is filing for his/herself, leave the space blank.
13. Enter the representative's relationship to the patient.
14. Enter the representative's phone number. Check box to indicate if it is okay to leave a message at this phone number.
15. Enter the representative's address.
16. Enter the patient's signature if the patient agrees to be represented by this individual or entity.

PROVIDER AGENCY WHERE ISSUE OCCURRED

17. Enter the provider agency's name.
18. Enter the name of the provider agency's contact person.
19. Enter the contact person's phone number.
20. Enter provider agency's address.
21. Enter provider agency's fax number.

INFORMATION ABOUT YOUR COMPLAINT / GRIEVANCE / APPEAL

22. Describe the nature of the issue you would like addressed. Include any important information about the incident, such as the date, person(s) involved, etc. Attach additional sheets, if needed.
23. Explain how you have tried to resolve this issue and your proposed resolution. Include any information on whether you have contacted the above mentioned provider agency, the date you contacted the agency, the name(s) of the person(s) you spoke with, the outcome, etc. What is your proposed solution?
24. Enter your signature here.
25. Enter the date you submitted the complaint/grievance or appeal.

INTERNAL SAPC USE ONLY

This section reserved for internal SAPC use only.

SUBMIT THE COMPLAINT / GRIEVANCE / APPEAL FORM TO:	
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