Grievance, Appeal, or Expedited Appeal Form

-Return this completed form to the front desk, or you may request a postage-paid envelope to mail the form in to file a grievance, appeal, or expedited appeal-

Client Information:

Name ______________________________ Date of Birth ____________

Address ____

Phone/E-mail ______________________ Best way to reach me ___________

My problem or concern is about the following program or provider: ____________

Description of problem or concern: ______________________________

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What I would like to have happen: ______________________________

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I am filing a: ☐ Grievance ☐ Appeal ☐ Expedited Appeal

I authorize the following person to act on my behalf (*optional*) ______________

I understand that I will not be subject to discrimination as a result of filing a grievance, appeal, or expedited appeal.

Signature of client or legal guardian ______________________ Date _________

Signature, if not signed by
the client or legal guardian ______________________ Date _________

FOR OFFICE USE ONLY

Date received ____________ ☐ Grievance ☐ Appeal ☐ Expedited Appeal Oral report received by ____________

File Number ________________ Acknowledgement letter mailed on ______________________

Assigned to ______________________ or Referred to ______________________

County of Marin Department of Health & Human Services
Marin Mental Health Plan/Quality Improvement
20 N. San Pedro Rd., #2028, San Rafael, CA 94903

IF YOU NEED ASSISTANCE TO COMPLETE THIS FORM:

- You may ask any Mental Health staff to assist you.
- You may call the Marin Mental Health Plan at the 24 hour toll-free access line at 1 (888) 818-1115 TTY 1 (800) 855-2881.
- You may call the Patients' Rights Advocate at (415) 526-7525.

Filing a complaint, grievance, appeal, or expedited appeal will not affect your ability to obtain services.

09/15

State Fair Hearing

A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the specialty mental health services to which you are entitled under the Medi-Cal program.

You can ask for a State Fair Hearing by writing to:

State Hearing Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

To request a State Fair Hearing you may also call 1 (800) 952-5253 or send a fax to 1 (916) 229-4110.

County of Marin

Department of Health & Human Services

Mental Health & Substance Use Services

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