



**SUBSTANCE ABUSE PREVENTION AND CONTROL  
PROVIDER COMPLAINT / GRIEVANCE / APPEAL FORM**

SUBMIT COMPLAINT/GRIEVANCE/APPEAL FORM TO:

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

To check submission status call: (XXX) XXX-XXXX

1. (Check one): <input type="checkbox"/> Complaint / Grievance <input type="checkbox"/> Expedited Appeal <input type="checkbox"/> Standard Appeal		2. Submission Date:	3. Reference Number:
<b>PATIENT INFORMATION (if not applicable, check here <input type="checkbox"/> )</b>			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>INFORMATION OF PATIENT REPRESENTATIVE (if not applicable, check here <input type="checkbox"/> )</b>			
12. Name:		13. Relationship:	14. Representative's Phone Number:
15. Address:			Okay to Leave a Message? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Patient signature, if patient authorizes the above named person/entity to serve as legal representative:			
<b>PROVIDER AGENCY</b>			
17. Provider Agency Name:		18. Contact Person:	19. Phone Number:
20. Address:			21. Fax Number:
<b>INFORMATION ABOUT YOUR COMPLAINT / GRIEVANCE / APPEAL</b>			
22. Please describe the nature of the issue. Include any important information about the incident, such as the date, person(s) involved, etc. Attach additional sheets, if necessary.			
23. Please describe how you have tried to resolve this issue and your proposed resolution. Attach additional sheets, if necessary.			
24. Signature:			25. Date:
<b>INTERNAL SAPC USE ONLY</b>			
<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Refer to Medical Director/Designee			
Comments:			
Reviewed by:			Date:
Medical Director/Designee Decision: <input type="checkbox"/> Approved <input type="checkbox"/> 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, HIPAA Privacy Standards, and 42 CFR Part 2. 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.	Patient 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 (if not applicable, check box)**

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 not applicable, check box)**

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**

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 necessary.
23. Explain how you have tried to resolve this issue and your proposed resolution. Attach additional sheets, if necessary.
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.

**THE COMPLAINT / GRIEVANCE / APPEAL TIMETABLE**

Description	Receipt Notification	Decision Notification	Written Decision Notification
Complaint/Grievance	Within three (3) calendar days of receipt of complaint/grievance	As expeditiously as the client's health condition requires and within sixty (60) calendar days of receipt of complaint/grievance	Within sixty (60) calendar days of receipt of complaint/grievance
Standard Appeal for Residential Reauthorizations, Grievance Decisions, etc.	Within three (3) calendar days of appeal	As expeditiously as the client's health condition requires and within forty-five (45) calendar days of receipt of appeal	Within forty-five (45) calendar days of receipt of appeal
Expedited Appeal for Initial Residential Authorizations and Medication-Assisted Treatment.	Within two (2) business days of appeal	Verbal notification will be given as soon as possible but no later than three (3) business days of receipt of appeal	Within three (3) business days of receipt of appeal

If request for expedited resolution of an appeal is denied, it will be transferred to the timeframe for standard resolution. Written notification of this change to a standard appeal process will be provided Within two (2) business days of receipt of appeal request

You may request a State Fair Hearing by submitting a written request within ninety (90) calendar days of the written notice of denial to:

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

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