Filing a State Fair Hearing You may request a State Fair Hearing by calling (800) 952-5253. Your current services will continue without disruption until a decision is reached. A Client may request a State fair hearing only after receiving notice (letter) that we are upholding the adverse benefit determination or the client has exhausted the appeal process. In the case that we fail to adhere to the notice and timing requirements stated above, you are deemed to have exhausted our appeals process and may initiate a State fair hearing. Clients must request a State fair hearing no later than 120 calendar days from the date you received the notice of resolution.

Medi-Cal Beneficiaries may file a complaint directly with:

Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413
Or call the Office of the Ombudsman at
(916) 896-4042

Clients not covered by Medi-Cal may also file a complaint by calling the Department of Health Care Services SUD Compliance Division at (877) 685-8333.

Visit www.bit.ly/consumer_forms to view a complete list of rights for individuals receiving services from residential alcohol or drug abuse treatment facilities.

Santa Clara County Behavioral Health Services Department
Attn: Quality Assurance Program
P.O. Box 28504, San Jose, CA 95159-9903

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P.O. Box 28504, San Jose, CA 95159-9903

Place stamp here. Post office will not deliver without First

We will provide you reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

We will ensure that individuals who make decisions on grievances and appeals are individuals:

- Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual;
- Who, if deciding on issues related to medical necessity, an expedited grievance or appeal, or a clinical issue are individuals who have the appropriate clinical expertise, as determined by us, in treating the client's condition or disease; and
- Who, take into account all comments, documents, records, and other information submitted by the client or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

We will provide you (and your representative/estate) your case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by us or our subcontractors in connection with the appeal of the adverse benefit determination. This information will be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

Your Grievance and Appeal Rights

SANTA CLARA COUNTY
Behavioral Health Services

Grievance & Appeal Process Our process for handling your grievance/appeal of adverse benefit determinations includes sending you an acknowledgement receipt of each grievance and appeal and a resolution notice. There will be no retaliation or discrimination for expressing a concern or filing a grievance. We will resolve each grievance and appeal, and provide notice, as expeditiously as your health condition requires within the timelines listed below. You may file a Grievance at any time to express dissatisfaction about any matter other than an adverse benefit determination. Grievance includes your right to dispute an extension of time proposed by us to make an authorization decision. You may share evidence and testimony and make legal and factual arguments in person, on the phone or in writing at any time. Standard resolution of grievances will not exceed 90 calendar days from the day that we receive the grievance.

How to File a Grievance:

- For mental health services (MHS), call (408) 793-5894
- For substance use treatment services (SUTS), call (408) 792-5666
- Complete and mail/fax this form or a letter
  SUTS Fax# 408-947-8707
  MHS Fax # 408-288-6113

Appeal An appeal is a review by us of an adverse benefit determination. Following receipt of a notification of an adverse benefit determination, you have 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal. We have only one level of appeal for clients. You may request a State fair hearing after receiving notice of an adverse benefit determination is upheld. You may request an appeal either orally or in writing. Further, unless you request an expedited resolution, an oral appeal must be followed by a written, signed appeal. Your benefits will continue pending resolution of the appeal. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and will be confirmed in writing, unless you or your provider requests expedited resolution.

Adverse Benefit Determination Means The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. We reduce, suspend, or terminate any previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner. Failure to adhere to the timeframes regarding the standard resolution of grievances and appeals. For a resident of a rural area, the denial of an enrollee's request to exercise his or her right, to obtain services outside the network. The denial of a client's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other client's financial liabilities.

Expedited Appeals Standard resolution of appeals will not exceed 30 calendar days from the day we receive the appeal: unless a 14 day extension is granted due to your request to extend. We determine the need for additional information, or if the delay is in your interest.

Expedited resolution of appeals. 72 hours after we receive the appeal. This timeframe may be extended only be extended up to 14 calendar days if you request the extension; or we show (based on the states standards) that there is need for additional information and how the delay is in your interest. If there is a timeframe extension, we *will*: make reasonable efforts to give you prompt oral notice of the delay and within 2 calendar days give you written notice of the reason for the decision to extend the timeframe and inform you of your right to file a grievance if you disagree with that decision. We will resolve appeals as expeditiously as the client's health condition requires and no later than the date the extension expires.

Expedited Resolution of Appeals. When we determine (for a request from the enrollee) or a provider indicates (in making the request on the your behalf or supporting the your request) that taking the time for a standard resolution could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function the grievance and/or appeal must be expedited. If we deny a request for expedited resolution of an appeal, we must transfer the grievance and/or appeal to the timeframe for standard resolution (as stated above).

Detach, fold, seal and return this

GRIEVANCE FORM

TYPE OF REQUEST (check one)

Grievance ☐ Appeal ☐

Expedited Grievance ☐ Expedited Appeal ☐

Client / Consumer Name	**Date of Birth**
Address	**City/State/Zip**
Phone	**Program/Staff**

Describe the problem or concern:

Signature **Date**