SONOMA COUNTY
DEPARTMENT OF HEALTH SERVICES

BEHAVIORAL HEALTH DIVISION

Department of Health Services, Behavioral Health Division (DHS-BHD) clients 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:
Grievance Coordinator
2227 Capricorn Way, Suite 207
Santa Rosa CA 95407-5419

Phone: 707-565-7895 or 1-800-870-8786
TTY: 800-735-2929 or 711

CLIENT RIGHTS

As a client of DHS-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 DHS-BHD beneficiaries with Medi-Cal can file an appeal, expedited appeal, or a request for a State Hearing without retaliation.

SONOMA COUNTY BEHAVIORAL HEALTH DIVISION GRIEVANCE

DHS-BHD is committed to finding solutions to the issues you may encounter when receiving behavioral health services. DHS-BHD will not discriminate against, or treat unfairly any person who files a grievance, appeal, or expedited appeal.

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 DHS-BHD Medi-Cal beneficiaries. For questions or assistance with filing a grievance, or an appeal, please call:

Grievance Coordinator
Phone: 707-565-7895 or 1-800-870-8786
TTY: 1-800-735-2929 or 711

Information and form are located at:
http://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

FILING A GRIEVANCE

Grievance filers are encouraged (but not required) to discuss their grievance with DHS-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 DHS-BHD Grievance Coordinator.

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.

Within **90 calendar days**, DHS-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.

APPEALING A NOTICE OF ADVERSE BENEFIT DETERMINATION

DHS-BHD Medi-Cal beneficiaries have the right to file an appeal within **60 calendar days** of the Notice of Adverse Benefit Determination (NOABD) issuance.

NOABDs are issued when DHS-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 beneficiary's request to dispute financial liability.

Appeals can be filed verbally or in writing. However, after making a verbal appeal, a written appeal must be submitted to DHS-BHD by the beneficiary, or their authorized representative.

A written acknowledgement of the appeal will be sent to the beneficiary within **5 calendar** days of receipt.

The appeal will be reviewed and a written Notice of Appeal Resolution (NAR) will be provided to the beneficiary within **30 calendar** days of the appeal receipt.

DHS-BHD may extend the resolution timeframes for appeals by up to **14 calendar** days, if either of the following conditions apply: the beneficiary requests the extension; or DHS-BHD determines there is a need for additional information and explains how the delay is in the beneficiary's best interest.

Notice of extensions will be provided to the beneficiary within **2 calendar** days of the decision to extend the timeframe, under certain circumstances. For any extensions that were not requested by the beneficiary, DHS-BHD will provide the beneficiary with a written reason for delay.

APPEALING A NOTICE OF ADVERSE BENEFIT DETERMINATION (continued)

DHS-BHD will resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the **14 calendar** day extension.

Expedited Appeal:

An expedited appeal may be requested if the beneficiary or their provider decides that a standard appeal could seriously jeopardize the beneficiary's life, health, or the ability to attain, maintain or regain maximum functioning.

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 beneficiary no later than **72 hours** after receipt.

Timeframes for expedited appeals can be extended for up to **14 calendar days**.

FILING A STATE HEARING

DHS-BHD Medi-Cal beneficiaries have the right to request a State Hearing. Beneficiaries must exhaust the DHS-BHD appeal process prior to requesting a State Hearing.

Beneficiaries may request a State Hearing in response to receiving a NAR concerning the outcome of a NOABD. Or if DHS-BHD fails to adhere to NOABD or NAR issuance timeframes.

The beneficiary has **120 calendar** days from the NAR date to request a State Hearing. If the beneficiary 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.

When performing *Standard Hearings*, the State must reach its decision on the hearing within **90 calendar** days of the date of the request for the hearing.

When performing *Expedited Hearings*, the State must reach its decision on the hearing within **3 working** days of the date of the request for the hearing.

To request a State Hearing, call State Hearing Division in Sacramento:

PHONE: 1-800-952-5253
TDD: 1-800-952-8349

NOTICE TO CLIENTS

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.

In addition to filing a grievance with DHS-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.

GRIEVANCE / APPEAL / EXPEDITED APPEAL FORM

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

Name of Client: _____ 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 Client: _____

** 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, Suite 207, Santa Rosa, CA 95407-5419
Phone: (707) 565-7895 TTY: 1-800-735-2929 or 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.

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *24/7 toll-free 1-800-870-8786 toll free number or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call *707-565-6900 or 1-800-870-8786* (TTY: *1-800-735-2929 or 711*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*) 번으로 전화해 주십시오.

繁體中文(Chinese)
注 意 ： 辅 助 工 具 和 服 务 ， 包 括 但 不 限 于 大 字 体 文 件 和 替 代 格 式 。
包 括 但 不 限 于 大 字 体 文 件 和 替 代 格 式 。
如 果 您 提 出 要 求 ， 我 们 将 免 费 为 您 提 供 。 请 致 电 *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*)。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY: *1-800-735-2929 or 711*) *1-800-870-8786 or 707-565-6900* تماس بگیرید.

日本語(Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*) ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم *1-800-870-8786 or 707-565-6900* (رقم هاتف الصم والبكم: *1-800-735-2929 or 711*)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).

ខ្មែរ(Cambodian)

ប្រយ័ត្ន៖ រ សើ ិនជាអ្នកនិយាយ ភាសាខ្មែ , រសវាជំនួយមននកភាសា រោយមិនគិត្ច ្ល ន
គឺអាចមានសំរា ់ ំរ អុើ នក។ ចូ ទូ សព្ទ *1-800-870-8786 or 707-565-6900*
(TTY: *1-800-735-2929 or 711*)។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວ ້ າພາສາ ລາວ, ການບໍ ລິ ການຊ່ວຍເຫ ືອດ້ານພາສາ, ໂດຍບໍ ່ ເສ ັ ງຄ່ າ,
ແມ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ່ ານ. ໂທຣ *1-800-870-8786 or 707-565-6900* (TTY: *1-800-735-2929 or 711*).