

MEMBER INTENT TO FILE AN APPEAL

This “**Intent to File an Appeal**” form is to request review of a decision when services are denied, reduced, or terminated and/or if there has been an inappropriate delay in service or in the Problem Resolution Process. An Appeal must be filed within 60 days of the date of the Notice of Action. There is no deadline for filing an Appeal when no Notice of Action was sent. Expedited Appeals must be requested (verbally or in writing) within 10 days. Appeals will be addressed within 30 days of filing, unless expedited (i.e. waiting will jeopardize life, health or ability to maintain or regain maximum function), in which case a decision will be made no longer than 72 hours after NCBH receives the request for expedited resolution (contact the Patients’ Rights Advocate regarding Expedited Appeals).

The “**Intent to File a Grievance**” form is only used when a client wants to express dissatisfaction about issues regarding the provision of mental health services that are not covered by an Appeal (e.g. quality of care or services; rudeness of an employee; or failure to respect a client’s rights). Both forms can be found in the provider lobby, requested from the Patients’ Rights Advocate or online at <https://www.nevadacountyca.gov/2170/Quality-Assurance>. Written confirmation that your Appeal was received will be sent within five business days.

For information regarding an Appeal and/or a Grievance or to file an appeal orally please contact the Patient Rights Advocate at 530-265-1437. For more detailed information, reference the Client Problem Resolution Guide <https://www.nevadacountyca.gov/DocumentCenter/View/24136/Client-Problem-Resolution-Guide> or the Nevada County Integrated MHP and DMC ODS Handbook on our website at <https://www.nevadacountyca.gov/DocumentCenter/View/52587/Nevada-MHP-and-ODS-Beneficiary-Handbook?bidId=>.

I, _____, am informing the

- Nevada County Behavioral Health Department, and/or
- Provider

of my request to initiate Appeal Proceedings regarding the provision of services at your facility. I understand that I will not be subject to discrimination or any other penalty for filing an Appeal. My printed information is as follows:

Name: _____ Phone: _____

Address: _____

Email Address: _____ Check if unhoused:

Medi-Cal #: _____ Date of Birth: _____

(circle one) Client Ex-Client Relative Friend

Is this Appeal related to a Transgender, Gender Diverse, or Intersex Discrimination Grievance?

Yes No

Nature of Appeal (date occurrence, location, individual(s) involved, what service was denied, reduced, or terminated and/or explain the inappropriate delay in service or in the problem resolution process:

I filed an Expedited Appeal (explain how a standard appeal could jeopardize your life, health, or ability to achieve, keep, or gain your maximum life functions):

What steps, if any, did you take to resolve the issue (whom did you talk to, when, and what response did you get):

Member Signature

Date

I give permission to contact me regarding this Appeal via text message or email: Yes No