CLIENT GRIEVANCE OR APPEAL FORM

If you have a problem with your **INPATIENT/RESIDENTIAL** mental health or substance use disorder services, call the Jewish Family Service (JFS) Patient's Advocacy Program at the phone number below or mail this form (self-addressed envelopes shall be made available at the program you are receiving services from).

To file by mail, send to:	**To file a grievance or appeal by phone, call:**
Jewish Family Service of San Diego **Joan & Irwin Jacobs Campus** **Turk Family Center Community Services Building** 8804 Balboa Avenue San Diego, CA 92123	**619-282-1134 or 1-800-479-2233** *We strongly encourage clients to call for faster service*

WHAT IS A GRIEVANCE OR APPEAL?	
A "grievance" is an expression of unhappiness about anything regarding your mental health or substance use disorder services.	**An "appeal"** can be made when the authorization for services is denied, reduced, or stopped. **An "expedited appeal**" can be made when you or your provider certify that the standard appeal timeline could seriously risk your life, health, or ability to function.

We need to be able to contact you in order to assist.

Please provide information that will make it easy for us to contact you even after you have left this facility.

Name		**Mailing Address**	
Phone No.		**Email**	
Best method of contact	☐Phone ☐Mail ☐Email		

List the name of program/facility you are filing the grievance or appeal about below
Tell us about your issue below (use back of form if more space is needed)

PROGRAM NOTICE: This form must be made readily available to clients and in an area where they can independently obtain the form. This form and process shall not be replaced by any internal program grievance or complaint process.

FOR OFFICE USE ONLY: Date Received _____

The County of San Diego follows State and Federal civil rights laws and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. Do you believe you have been discriminated, excluded, or treated differently based on any of the above protected classes while accessing mental health or substance use disorder services? ☐ Yes ☐ No (**If Yes**, please explain below)

Client Signature		**Date**	

If this form is being completed by an authorized representative (AR) for the client, please complete below:

Name of Authorized Representative		**Date**	
Signature of Authorized Representative		**Relationship to Client**	

For more information on the Grievance and Appeals Process, ask for a copy of the **Integrated Behavioral Health Member Handbook (DMC-ODS & SMHS)** at the program/facility you are receiving services from.

This information is also available electronically at the following link:
https://www.optumsandiego.com/content/SanDiego/sandiego/en/beneficiary_and_families.html

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