

# Sierra County Health and Human Services

## Appeal and Grievance Form

**\*\*Filing an Appeal/Grievance will not adversely affect the services you receive from Sierra County Health and Human Services. The client will be contacted by the Appeal/Grievance officer within the required timeframes. Please mail or fax this form to the address on the bottom of this form\*\***

**I am filing a** (check one):  Appeal  Grievance  Expedited Appeal  
(Check Appeal if you have had a service denied or reduced and you disagree with this decision. Check Grievance for any other complaint.)

**Name of the client filing Appeal/Grievance:** \_\_\_\_\_

**I am** (check one):  A Client  Acting on a Client's Behalf  Other \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_ ( \_\_\_\_ ) \_\_\_\_\_

**Please summarize the problem(s) you have had using specific details. Please attach additional sheets as necessary:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please describe what you have done to try to resolve the problem:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please make any suggestions for resolution:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**If you would like information about this Appeal/Grievance to be given to anyone, please list their name(s) here:**

\_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of person acting on client's behalf:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For County Use Only**

Date written response sent to client: \_\_\_\_\_

Resolution: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of County Staff: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail or fax this form to:**

**Sierra County Behavioral Health Department- Director of Health and Human Services**

**P.O. Box 7- 202 Front Street Loyaltan, California 96118**

**Phone: 530-993-6707 Fax: 530-993-6741**