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 Loyalton, California 96118

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