Placer County Systems of Care Appeal/Grievance Form

Note: Filing an Appeal/Grievance will not adversely affect the services you receive from Placer County Systems of Care. The client will be contacted by the QI Department within 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 <u>any</u> other complaint.)

Type of service: ☐ Mental Health ☐ Substance Use

Name of client filing Appeal/Grievance: ___________________________________

I am (circle one): ☐ Client ☐ Acting on Client’s Behalf ☐ Other ____________

Mailing Address: ____

Telephone Number: (_____) ____

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

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

____

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Please make any suggestions for resolution:

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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

Resolution: ____

____

____

Signature of County Staff: ____________________________ Date:____________

Date written response sent to client:____________________________________

Mail or fax this from to:

Placer County Systems of Care
Quality Management Designee
101 Cirby Hills Drive
Roseville, CA 95678
Phone: 916-787-8979 or 530-886-5419
Fax: 916-872-6521