BENEFICIARY/CLIENT GRIEVANCE OR APPEAL AND AUTHORIZATION FORM

You may file a GRIEVANCE at any time.
You may authorize another person to act on your behalf.

You have the right to file an APPEAL with the HEAD OF SERVICE when you are

1. **Denied or limited authorization of a requested service;**
2. **Reduced, suspended, or terminated a previously authorized service;**
3. **Denied, in whole or in part, payment for a service;**
4. **Changed services or fails to provide them in a timely manner;**
5. **Failed to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.**

Person Filing the Grievance or Appeal

LAST NAME: _____ FIRST NAME:_____

DATE OF BIRTH: _____ MEDI-CAL#:_____

ADDRESS:_____ CITY:_____ ZIP:_____

PHONE:_____

Grievance or Appeal Filed Against

FACILITY: _____ 8019 S. Compton Ave. _____18220 S. Broadway Ave.

NAME OF PROVIDER:_____

PROGRAM:_____

You will not be subject to discrimination or any other penalty for filing a grievance or appeal. Your confidentiality will be protected at all times in accordance with State and Federal law.

DESCRIPTION OF GRIEVANCE or APPEAL: (Please submit any supporting written documents with the Grievance or Appeal. Use additional sheets if needed.)

Signature of Client/Client's Representative **Date**

If signed by client's personal representative, state relationship and authority to do so.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION:

If you sign this document, you give permission to the TCCSC to investigate your Grievance or Appeal. This Authorization will allow your health care providers to disclose the following health information to TCCSC to investigate your Grievance or Appeal:

- **Your past and current medical records; and**
- **Other information relating to your grievance or appeal and/or denial or rights.**

Expiration Date:
This Authorization will expire on the date of the resolution of your Grievance or Appeal.

Your Rights Regarding This Authorization:
If you agree to sign this Authorization, you must be provided with a signed copy of this form.

You do not have to sign this Authorization, and your refusal will not affect your ability to obtain treatment.

You can revoke or cancel your Authorization to allow use of your health information at any time by telling Los Angeles County – Department of Mental Health in writing. You must sign your revocation request and mail or deliver it to:

TESSIE CLEVELAND COMMUNITY SERVICES CORP.
HEAD OF SERVICE
8019 S. COMPTON AVE.
Los Angeles, CA 90001

If you revoke this Authorization, we may still use and share your health information that has already been obtained for reasons related to prior reliance of this Authorization.

Authorization Approval: By signing this form, I authorize the use or disclosure of the health information described above. I understand that my health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed unless another authorization is received from me or such use or disclosure is specifically permitted or required by law.

Signature of Client/Client's Representative **Date**

If signed by client's personal representative, state relationship and authority to do so.

YOU HAVE THE RIGHT TO FREE LANGUAGE ASSISTANCE SERVICE.

CALL THE HEAD OF SERVICE AT

(323) 586-7333

- **Did you complete the information requested on the form?**
- **Did you list your phone number and address where we can contact you?**
- **Did you sign both the Grievance or Appeal section on page 2 and the Authorization section on this page?**

Please mail to:

TESSIE CLEVELAND COMMUNITY SERVICES CORP.
HEAD OF SERVICE
8019 S. COMPTON AVE.
Los Angeles, CA 90001

Please don't forget a postage stamp.