

**Patient's Rights**

**Butte County Department  
of Behavioral Health**



**Grievance,  
Appeal, and  
Expedited Appeal  
Request**

**(530) 343 – 1731  
or  
800-497-1445**

Quality Management Division  
Butte Co. Behavioral Health  
1196 E. Lassen #130  
Chico, CA 95973

Postage  
Required

Butte Co. Behavioral Health  
Quality Management Division,  
Clients' Rights  
1196 E. Lassen, Suite 130  
Chico, CA 95973

# **GRIEVANCE, APPEAL and EXPEDITED APPEAL PROCESS**

We will make every effort to satisfy the treatment needs of our clients. However, there may be times when clients will be unhappy with services received. Clients are encouraged to discuss issues regarding their mental health service directly with their provider. If efforts to resolve the problem directly are unsuccessful, clients who are dissatisfied with their mental health services may file a grievance. You may request a friend, relatives and/ or Clients' Rights Advocate to assist you with your grievance and hearing rights.

A client who has Medi-Cal may file for a State Fair Hearing only after they have filed for an Appeal and they have received a final decision about the Appeal from Butte County Behavioral Health. State Fair Hearings may no longer take place with regards to the Grievance process.

If you believe waiting the 30 days for an appeal decision may jeopardize your life, health, or ability to attain, maintain or regain maximum function, you may request an expedited appeal.

To register a grievance, an appeal, an expedited appeal or assistance with a State Fair Hearing call:

**Patients' Rights**  
**(530) 343-1731 or 800-497-1445**

Clients will not be subject to any penalty, discrimination or retaliation for filing a grievance or an appeal. Every effort will be made to resolve the issue at an informal level.

**BUTTE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH CLIENTS'  
RIGHTS RESOLUTION REQUEST FORM**

Please Check  
One:

Grievance

Appeal

Expedited  
Appeal

Date: \_\_\_\_\_

Do you have Medi-Cal?

Yes  No  Unsure

Name: \_\_\_\_\_

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

Telephone  
Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of Person filing Grievance,  
Appeal or Expedited Appeal, If  
other than yourself: \_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone  
number: \_\_\_\_\_

Email Address: \_\_\_\_\_  
\_\_\_\_\_

Problem:  
Please  
attach  
additional  
sheets if  
needed

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Signature

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Date

This form can be mailed to: Butte Co. Behavioral Health, Quality Management Division, Clients' Rights 1196 E. Lassen, Suite 130 Chico, CA 95973. For any questions or to speak with someone regarding your issue please call Clients' Rights at (530) 343-1731 or 800-497-1445.

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**For BCDBH Internal Use Only**

Date Received:

Date Forwarded:

Program:

Has grievance been resolved:  Yes  No

Resolution Date:

If no, list attempts made by beneficiary's treatment team to resolve the client's grievance (include dates):

If yes, state the resolution/corrective Action Taken by PM/ Supervisor:

Additional Comments:

Signature

Date