

CLIENT GRIEVANCE OR APPEAL FORM

If you have a problem with your **INPATIENT/RESIDENTIAL** mental health or substance use disorder services, call the Jewish Family Service (JFS) Patient's Advocacy Program at the phone number below or mail this form (self-addressed envelopes shall be made available at the program you are receiving services from).

<p><u>To file by mail, send to:</u> Jewish Family Service of San Diego Joan & Irwin Jacobs Campus Turk Family Center Community Services Building 8804 Balboa Avenue San Diego, CA 92123</p>	<p><u>To file a grievance or appeal by phone, call:</u> 619-282-1134 or 1-800-479-2233</p> <p><i>We strongly encourage clients to call for faster service</i></p>
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WHAT IS A GRIEVANCE OR APPEAL?	
<p>A “grievance” is an expression of unhappiness about anything regarding your mental health or substance use disorder services.</p>	<p>An “appeal” can be made when the authorization for services is denied, reduced, or stopped.</p> <p>An “expedited appeal” can be made when you or your provider certify that the standard appeal timeline could seriously risk your life, health, or ability to function.</p>

We need to be able to contact you in order to assist.

Please provide information that will make it easy for us to contact you even after you have left this facility.

Name		Mailing Address	
Phone No.		Email	
Best method of contact	<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email		

List the name of program/facility you are filing the grievance or appeal about below

Tell us about your issue below (use back of form if more space is needed)

PROGRAM NOTICE: This form must be made readily available to clients and in an area where they can independently obtain the form. This form and process shall not be replaced by any internal program grievance or complaint process.

FOR OFFICE USE ONLY: Date Received _____

The County of San Diego follows State and Federal civil rights laws and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Do you believe you have been discriminated, excluded, or treated differently based on any of the above protected classes while accessing mental health or substance use disorder services?

Yes No

(If Yes, please explain below)

Client Signature		Date	
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If this form is being completed by an authorized representative (AR) for the client, please complete below:

Name of Authorized Representative		Date	
Signature of Authorized Representative		Relationship to Client	

For more information on the Grievance and Appeals Process, ask for a copy of the **Integrated Behavioral Health Member Handbook (DMC-ODS & SMHS)** at the program/facility you are receiving services from.

This information is also available electronically at the following link:

https://www.optumsandiego.com/content/SanDiego/sandiego/en/beneficiary_and_families.html

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BHS QA Rev. 08/2025