



COMPLAINT/GRIEVANCE – INSTRUCTIONS

The Department of Public Health Substance Abuse Prevention and Control (SAPC) is the specialty substance use disorder treatment plan for the County of Los Angeles. While receiving substance use disorder treatment or related services from a SAPC Contracted agency, you have the right to express grievances, complaints or concerns about the services you receive using the problem resolution process described below:

HOW THE PROBLEM RESOLUTION PROCESS WORKS – COMPLAINT/GRIEVANCE:

A grievance (or complaint) is an expression of unhappiness about anything regarding your substance use treatment or related services.

If you are unhappy with your substance use disorder, or related services with a contracted SAPC provider, you may file a grievance (or complaint).

- You will not be subject to discrimination for filing a grievance and it will not affect the services you receive.
- You may file a complaint at any time in writing (e-mail or mail) or verbally (in person or phone) with your provider or directly with SAPC (see contact information below).
- You may authorize another person to act on your behalf, including your provider.
- Your confidentiality will be protected according to government laws (*W&I 5328* and *42 CFR Part 2*).
- Your complaint will be investigated and resolved within 90 days from the date the complaint is received by SAPC, unless a 14-day extension is granted.
- If you disagree with a complaint/grievance decision, you may refile a grievance for review.

If you are a Medi-Cal recipient, you also have the right to file an **appeal** if you receive a Notice of Adverse Benefit Determination (NOABD) telling you of a decision to deny or change your treatment or related services. Ask your provider or go to the SAPC website to find the Appeal Form at:

<http://publichealth.lacounty.gov/sapc/PatientPublic.htm>.

Tell us about your complaint by completing the form provided on Page 2.
If you need assistance completing this form, call 1-626-299-4532.

SUBMIT THE COMPLAINT/GRIEVANCE BY:

Email: sapc_appeal@ph.lacounty.gov	Mail: Substance Abuse Prevention and Control, Contracts and Compliance Branch 1000 South Fremont Avenue, Building A9 East, 3 rd Floor, Box 34, Alhambra, California 91803
Phone: (626) 299-4532	
Fax: (626) 458-6692	
If you need this form in alternate format (e.g. large print, braille, or audio), call 1-888-742-7900 press 7.	

For more information on the problem resolution process, please refer to your patient handbook or visit us at <http://publichealth.lacounty.gov/sapc/PatientPublic.htm>.



COMPLAINT/GRIEVANCE FORM

1. Date:		
PERSON FILING THE GRIEVANCE		
2. Name (Last, First, and Middle): <i>(required)</i>		3. Sage Patient ID#: <i>(if known)</i>
4. Authorization # <i>(if known)</i>		
5. Date of Birth: <i>(required)</i>	6. Medi-Cal #: <i>(if known)</i>	7. Street Address: <i>(required if there is an address available)</i>
8. City and Zip Code <i>(required if there is an address available)</i>	9. Phone Number and/or Email Address: <i>(required if there is a phone or email address available)</i>	10. Do we have your permission to leave a voice message? ☐ Yes ☐ No
COMPLETE IF AUTHORIZING A REPRESENTATIVE TO FILE A COMPLAINT ON YOUR BEHALF		
11. Name of Representative:	12. Agency Name/Relationship:	13. Email:
14. Street Address:	15. City and Zip Code:	16. Phone:
17. If you are authorizing another person or entity to represent you in filing this complaint/grievance, please sign below:		
_____ Patient Name (Print)		_____ Patient (Signature)

INFORMATION ABOUT YOUR GRIEVANCE

18. Grievance/Complaint Type (check all that apply):

- ☐ Service not available/accessible
- ☐ Enrollment/disenrollment issues (Med-Cal Only)
- ☐ Problems with payment to provider
- ☐ Staff issues/customer service

- ☐ Denied Services/Referral/Appointment
- ☐ Patient Rights violation
- ☐ Quality/appropriateness of care
- ☐ Billing
- ☐ Other: _____

19. Site/Facility Address: _____

20. Please provide detailed information about the complaint/grievance. Attach additional pages or supporting documentation, if needed.

Signature of Person or Authorized Representative

Date

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