YOLO COUNTY DEPARTMENT OF ALCOHOL, DRUG, AND MENTAL HEALTH SERVICES

Client Appeal Form

Client Rights

You have the right to file an Appeal with Yolo County Department of Alcohol, Drug, and Mental Health. You will not be subject to penalty for filing an Appeal. If you received a Notice of Action and would like to appeal the decisions given in the Notice of Action (such as a denial of mental health services), this is the correct form. Staff is available to assist you if needed.

You can present evidence in favor of your appeal during the Appeal Process, in writing or in person. You, or your representative, also have the right to examine your chart and any other documents that are relevant to your Appeal.

You have the right to request a State Fair Hearing at any time before, during, or after the Appeal Process has begun.

Please return the completed Client Appeal Form to Yolo County Department of Alcohol, Drug, and Mental Health Services, either by hand or mail. Self-addressed envelopes are provided in the office.

After you return the completed Appeal Form you will receive a written notice of receipt. A decision about your Appeal will be made within 45 calendar days after your Appeal has been received. You will receive the decision in writing.

Acknowledgement of Appeal Process

I authorize Yolo County staff to contact any involved provider in order to resolve my Appeal. Yolo County is also authorized to discuss any and all information that is needed to evaluate and resolve this Appeal.

Signature **Date**

Assigning a Representative

You may authorize another person, including a provider, to act on your behalf during the Appeal Process. To authorize another person to act on your behalf, please complete the following information.

For the purpose of resolving this Appeal, I authorize the following person to act on my behalf (please write "n/a" if you will not have anyone acting on your behalf):

Representative Name _____

Street Address _____

_____

City _____ Zip Code _____

Phone Number _____

Client Contact Information

Client Name _____

Date of Birth _____ _____

Street Address _____

_____

City _____ Zip Code _____

Phone Number _____

Authorization to Contact Personal Representative

By signing this form, I authorize Yolo County staff to contact my personal representative with information about my Appeal.

Signature **Date**

Appeal Description--OVER

Appeal Description

Describe your Appeal. Please include a copy of the Notice of Action that you received, if possible.

You have a right to file an expedited appeal if your life, health, or ability to function will be affected by the standard appeal process. Yolo County has a right to deny the request for an expedited appeal and handle the request as outlined in this form. For more information, please see the ADMH Client Problem Resolution Guide or ask staff.

☐ **I Request an Expedited Appeal**

Signature **Date**