CLIENT G	RIEVANCE	
API	PEAL	
	EXPEDITED APPEAL	
might have, <i>except if the dissati</i> (NOABD) from Inyo County Beh decision given in the NOABD (su	vance with Inyo County Behavioral Heas sfaction is about receiving a Notice of pavioral Health. If you received a NOA ch as you were denied health services) you a NOABD, please ask a staff person for	<i>Adverse Beneficiary Determination</i> ABD and would like to appeal the you should <u>not</u> use this form. If you
Client Name:	C	lient D:
Mailing Address (so that we may contact y	ou about your grievance)	
Street Address	City	Zip Code
Date that the problem occurred:		
writing that Inyo County Behavioral Health	ives your completed form, a staff person will stamp has received your grievance and is in the process o w what the result of your grievance is within 60 day	of investigating it. In most cases, Inyo

INYO COUNTY BEHAVIORAL HEALTH

FOR OFFICE USE ONLY

For more information about filing a grievance, please read the Inyo County Behavioral Health Problem Resolution Guide or contact Inyo County Behavioral Health at (760) 873-6533.

CONFIDENTIAL PATIENT INFORMATION (SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328)