

## California Children's Services Program Grievance Intake

**Privacy Notice:** This form is used to collect personal information from CCS applicants, beneficiaries, and/or representatives who may have a grievance with DHCS and county CCS programs. The personal information collected on and with this form is private and confidential and is requested by DHCS' Integrated Systems of Care Division, and county CCS programs. Any personal information collected on and with this form by DHCS is subject to limitations set forth in the Information Practices Act <sup>1</sup>, the Health Insurance Portability and Accountability Act (HIPAA)<sup>2</sup>, and other state policy. DHCS will not use or share your information unless authorized by you, or by the individual to whom it pertains, in writing or as authorized by law. The requested information is voluntary. CCS applicants, beneficiaries, and/or representatives should not provide personal information that is not requested. If you do not provide all information requested, it may delay the processing and resolution of your grievance. DHCS and/or county CCS programs may share or provide any of the information provided on or with this form to individuals and agencies who are responsible or can assist with resolving the grievance. In most cases, the individual(s) to whom this information pertains has the right to access it. For more information or to obtain access to records containing your personal information maintained by the Department, contact:

Integrated Systems of Care Division  
Attn: County Compliance Unit  
1501 Capitol Ave, MS 4502, PO Box 997437  
Sacramento, CA 95899-7437

DHCS is authorized to collect this information pursuant to California Welfare and Institutions (W&I) Code section 14184.600(b).<sup>3,4,5</sup> DHCS is also authorized to collect personal information for the administration of the Medi-Cal program.<sup>6,7</sup> For more information on DHCS' Privacy Practices, please review DHCS' Notice of Privacy Practices<sup>8</sup> and Privacy Policy Statement<sup>9</sup>.

If you wish to obtain a paper copy of DHCS' privacy policy and practices, or wish to file a complaint, you may contact the DHCS privacy officer by mail, email, or telephone:

Privacy Office  
c/o: Data Privacy Unit  
Department of Health Care Services  
P.O. Box 997413, MS 4722  
Sacramento, CA 95899-7413

Email: incidents@dhcs.ca.gov  
Telephone: (916) 445-4646

---

<sup>1</sup> [Information Practices Act](#)

<sup>2</sup> [HIPPA](#)

<sup>3</sup> [W&I Code § 14184.600\(b\)](#)

<sup>4</sup> [Health & Saf. Code, § 123925](#)

<sup>5</sup> [CCS Program Grievance Process NL 06-1023, or any superseding NL](#)

<sup>6</sup> [Civ. Code, § 1798.14](#)

<sup>7</sup> [Civ. Code, § 1798.15](#)

<sup>8</sup> [Notice of Privacy Practices](#)

<sup>9</sup> [Privacy Policy Statement](#)

The privacy notice provided here is required by California Civil Code 1798.17.<sup>10</sup>

**Instructions:** Complete this form and attach all supporting documentation to file a grievance. Grievances may be submitted over the telephone, in person, or in writing via email or mail.

**Include the following information on the Grievance Form:**

- |  |   |
|--|---|
| <ol style="list-style-type: none"> <li>1. Today’s date</li> <li>2. CCS beneficiary’s Identification Number (ID) or Medi-Cal Member’s Client Index Number (CIN)</li> <li>3. CCS beneficiary’s full name</li> <li>4. CCS beneficiary’s date of birth</li> <li>5. CCS beneficiary’s residential address</li> <li>6. CCS beneficiary’s city and zip code</li> <li>7. Phone number of who is filing the grievance</li> <li>8. Email of individual filing the grievance</li> <li>9. Full name of CCS beneficiary and/or representative filing the grievance</li> </ol> | <ol style="list-style-type: none"> <li>10. Relationship of individual filing the grievance, to CCS beneficiary</li> <li>11. Date of grievance, if different than today’s date</li> <li>12. Who was involved (If applicable)</li> <li>13. Where did the grievance take place (If applicable)</li> <li>14. Nature of the grievance, including the time, place, etc. Attach any additional information that may be relevant to your grievance.</li> <li>15. Requested resolution, if any (Optional)</li> </ol> |
|--|---|

Please contact your county CCS program or DHCS Monday – Friday, during standard business hours (except closed holidays) if you need help filing a grievance. Grievances may be filed through:

Classic and Whole Child Model Dependent Counties			
County	How to File	Entity	Contact Information
Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Imperial, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Modoc, Mono, Nevada, Plumas, San Benito, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba	Phone	DHCS	(916) 713-8300
	Email	DHCS	<a href="mailto:CCSMonitoring@DHCS.ca.gov">CCSMonitoring@DHCS.ca.gov</a>
	Mail	DHCS	Integrated Systems of Care Division Attn: County Compliance Unit 1501 Capitol Ave, MS 4502, PO Box 997437 Sacramento, CA 95899-7437
	In Person	County CCS Office	The addresses for all county offices are listed on the DHCS Web Page <sup>11</sup>

<sup>10</sup> [California Civil Code 1798.17](#)

<sup>11</sup> [County Offices for California Children’s Services \(ca.gov\)](#)

<b>Classic and Whole Child Model Independent Counties</b>			
<b>County</b>	<b>How to File</b>	<b>Entity</b>	<b>Contact Information</b>
Alameda, Butte, Contra Costa, Fresno, Humboldt, Kern, Los Angeles, Marin, Mendocino, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Tulare, Ventura, Yolo	Phone, Email, Mail, or In Person	County CCS Office	The addresses, emails, and phone numbers for all county offices are listed on the DHCS Webpage <sup>12</sup>

<sup>12</sup> [County Offices for California Children’s Services \(ca.gov\)](https://www.dhcs.ca.gov/Programs/Pages/County-Offices-for-California-Childrens-Services.aspx)

## Admisión de quejas del Programa de Servicios para Niños de California

Este formulario es para presentar una queja formal con respecto a la insatisfacción con el programa CCS, excepto para aquellos identificados en un Aviso de acción.

1. La fecha de hoy	2. Cédula de identidad/CIN del beneficiario de CCS	3. Nombre completo del beneficiario de CCS	
4. Fecha de nacimiento	5. Número de teléfono	6. Dirección de correo electrónico	
7. Dirección residencial		8. Ciudad	9. Código postal
10. Nombre completo de la persona que presenta la queja		11. Relación con el beneficiario de CCS <input type="checkbox"/> Solicitante/Beneficiario de CCS <input type="checkbox"/> Tutor legal <input type="checkbox"/> Representante Autorizado	
<b>Naturaleza de la queja</b>			
12. Fecha de la queja	13. ¿Quién estuvo involucrado? (Si corresponde)	14. ¿Dónde tuvo lugar? (Si corresponde)	
15. Indique la naturaleza de la queja, hechos, tiempos, lugares, etc. Adjunte cualquier información adicional que pueda ser relevante para su queja.			
16. Resolución solicitada (opcional)			

Si DHCS o el programa CCS del condado está completando este formulario para un solicitante, beneficiario y/o representante de CCS, complete lo siguiente:

Especifique condado o DHCS	Nombre del personal de CCS que completa este formulario
----------------------------	---

Para que el DHCS o el programa CCS del condado lo completen	
Nombre completo del representante responsable de resolver la queja	
Tipo de queja <input type="checkbox"/> Estándar <input type="checkbox"/> Acelerada	¿Es esto una queja de excepción? <input type="checkbox"/> Sí <input type="checkbox"/> No
Motivo de la excepción	
Fecha de resolución	
Descripción de las medidas adoptadas	
Fecha de envío de la notificación al solicitante, beneficiario y/o representante de CCS	

Para que lo complete el DHCS			
¿Está aprobada la excepción?	¿Quién otorgó la aprobación?	Fecha de aprobación	Fecha de notificación del condado