Our Mission
The mission of Contra Costa Behavioral Health, in partnership with consumers, families, staff, and community-based agencies, is to provide welcoming, integrated services for mental health, substance abuse, homelessness, and other needs that promote wellness, recovery, and resiliency while respecting the complexity and diversity of the people we serve.

Our Vision
Contra Costa Behavioral Health envisions a system of care that supports independence, hope, and healthy lives by making accessible, integrated, compassionate, and respectful behavioral health services that are responsive, integrated, compassionate, and respectful.

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (888) 678-7277 (TTY: 711).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call (888) 678-7277 (TTY: 711).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 678-7277 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ YÊU: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (888) 678-7277 (TTY: 711).

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (888) 678-7277 (TTY: 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888) 678-7277 (TTY: 711) 번으로 전화해 주십시오.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (888) 678-7277 (TTY: 711)。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցություններ:
Զանգահարեք (888) 678-7277 (TTY: 711)。

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 678-7277 (TTY: 711).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می یابد با (888) 678-7277 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (888) 678-7277 (TTY: 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए सहायता सेवाएं मुफ्त उपलब्ध हैं। (888) 678-7277 (TTY: 711) पर कॉल करें।

Thai (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (888) 678-7277 (TTY: 711).

Cambodian (Cambodian)
បង្កើតអំពីសុខភាព ។ ប្រឤក្តីសោលធនានាការ សមរម្យនិងការមុនប្រកួត ។ ដែលមានសុំចិត្ត ។ អាចប្រឹក្សាដំណេញ ដោយ ៨៨៨-៧២៧៧ ។ (888) 678-7277 (TTY: 711)។

Lao (Lao)
បង្កើតអំពីសុខភាព ។ ប្រឤក្តីសោលធនានាការ សមរម្យនិងការមុនប្រកួត ។ ដែលមានសុំចិត្ត ។ អាចប្រឹក្សាដំណាក់ ដោយ ៨៨៨-៧២៧៧ ។ (888) 678-7277 (TTY: 711)។
What is a Grievance?

A grievance is an expression of unhappiness about anything regarding your specialty mental health services that are not one of the problems covered by the appeal and State Hearing processes.

The Grievance Process

You can file a grievance anytime with CCMHP if you are unhappy with the specialty mental health services you are receiving from CCMHP or have another concern regarding CCMHP.

To get help with a grievance, you may contact any staff at your program, the Access Line at (888) 678-7277, CCMHP’s Office of Quality Improvement at (925) 957-5160 or the Grievance Advocate at (925) 293-4942. The CCMHP will provide self-addressed envelopes at all the providers’ sites for you to mail in your grievance. If you do not have a self-addressed envelope, you may mail your grievance directly to the address on this form. Grievances can be filed orally or in writing. Oral grievances do not have to be followed up in writing.

The State Hearing Process

CCMHP must make a decision about your grievance within 90 calendar days from the date you filed your grievance. The timeframes for making a decision may be extended by up to 14 calendar days if you request an extension, or if the CCMHP believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay might be for your benefit is when the CCMHP believes it might be able to resolve your grievance if they have more time to get information from you or other people involved. You can file for a State Hearing if your grievance wasn’t resolved in time.

A State Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the specialty mental health services to which you are entitled under the Medi-Cal program.

You can request a State Hearing directly from the California Department of Social Services by writing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

You can also call 1-800-743-8525 (TDD 1-800-952-8349) or a Grievance Advocate at (925) 293-4942.

If you have been unable to resolve a problem with your service provider by speaking directly to them or the supervisor of the program where you are receiving care, then you may request a change of a service provider by completing this form and giving it to the receptionist. The program supervisor will review your request and will notify you of his/her decision within ten (10) working days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a county operated clinic, call the Mental Health Access Line at 1(888) 678-7277. Submitting a request does not guarantee that they will change your provider. If you disagree with the decision, you may file a formal grievance.

DATE ___________________

TO: PROVIDER/PROGRAM SUPERVISOR
FROM: ____________________________________________

(Client Name)
________________________________________
(Parent or Guardian if request is by or for a child or youth)

I request a change in my Current Provider

(Please print name of current provider)

for the following reasons: (add additional pages as needed)

________________________________________

Check One:
☐ I have discussed my concerns with this provider.
☐ I have NOT discussed my concerns with this provider.

I understand serious consideration will be given to this request and that I can expect a response within ten (10) working days.

Respond to me by phone: ________________________________________

(Area Code and Telephone number)

or by mail: ________________________________________

(Street Address)

________________________________________

(City, State, Zip Code)