

# APPENDIX 9

# Memorandum

Date : July 22, 2008

To : All Inmate-Patients

Subject: **NEW HEALTH CARE APPEALS PROCESS – CORRECTED VERSION**

The purpose of the inmate appeal process is to respond to and resolve inmate-patient complaints in a timely manner. Currently, the Inmate Appeals Branch is responsible for the California Department of Corrections and Rehabilitation's inmate appeals process. In an effort to ensure health care involvement with this process, the Office of the Receiver will assume responsibility for all health care related appeals. This will include receipt, tracking, response to and reporting on all health care appeals effective August 1, 2008.

Following is a list of changes that will affect you:

## Institution Level Health Care Appeals

- A new health care appeal form has been approved and shall be made available to all inmate-patients. This new form is a CDCR Form 602-HC and is pink in color (copy attached).
- Beginning August 1, 2008, inmate-patients are expected to submit health care related appeals using the new (pink) form and all other appeals using the existing CDC Form 602 (green copy) *except* for Americans with Disability Act (ADA) appeals as discussed below.
- All appeals regarding health care issues shall be submitted directly to the Health Care Appeals Office at each institution.
- All ADA appeals must be submitted to the Institution Appeals Office using the CDC form 1824 (yellow copy).

## Director's Level Appeals

All Directors' Level Appeals regarding health care issues shall be submitted to:

Office of Third Level Appeals – Health Care  
P. O. Box 4038  
Sacramento, CA 95814-4038

All inmate-patients  
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If you have a health care related appeal that was submitted prior to August 1, 2008, it will continue to be processed until complete through the existing process. There is no need to re-submit the issue using a CDC Form 602-HC (pink copy.)

Thank you in advance for your cooperation. If you have any questions, please contact the Health Care Appeals Coordinator or the Institution Appeals Coordinator at your institution.

  
SUZAN L. HUBBARD  
Director  
Division of Adult Institutions

  
YULANDA MYNHIER  
Director (A)  
Plata Field Support Division

Attachment

cc: J. Clark Kelso  
John Hagar  
Terry Hill, M. D.  
Robin Dezember  
Scott Kernan  
Jeff Thompson  
Regional Medical Directors  
Associate Directors, Division of Adult Institutions  
Regional Directors of Nursing  
Regional Administrators  
Nola Grannis  
Theresa Kimura-Yip  
Wendy Feichter  
Health Care Managers  
Wardens  
Health Care Appeals Coordinators  
Inmate Appeals Coordinators

Location: Institution/Parole Region: Log #: Category:  
 1. \_\_\_\_\_ 1. \_\_\_\_\_ 1. \_\_\_\_\_  
 2. \_\_\_\_\_ 2. \_\_\_\_\_

You may appeal any policy, action or decision which has a significant adverse affect upon you. This form shall be used when the policy, action or decision being appealed involves health care services (medical, dental, or mental health services). You must first informally seek relief through discussion with the appropriate staff member or by utilizing the health care service processes at you institution. If you are not then satisfied, you may send your appeal with all the supporting documents and not more than one additional page of comments to the Health Care Appeals Coordinator within 15 days of the action taken. No reprisals will be taken for using the appeals procedure responsibility.

NAME	NUMBER	ASSIGNMENT	UNIT/ROOM NUMBER
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A. Describe Problem: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you need more space, attach one additional sheet.

B. Action Requested: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Inmate/Parolee Signature: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

**C. INFORMAL LEVEL (Date Received \_\_\_\_\_)**

Staff Response: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date Returned to Inmate: \_\_\_\_\_

**D. FORMAL LEVEL**

If you are dissatisfied, explain below, attach supporting documents (Health Care Service Request Form, CDC 7362, Comprehensive Accommodation Chrono, CDC 7410, Trust Account Statement, etc.) and submit for processing to the Health Care Appeals Coordinator at your location within 15 days of receipt of response.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

CDCR Appeal Number

**FIRST LEVEL:**  Granted  P. Granted  Denied  Other \_\_\_\_\_

E. REVIEWER'S ACTION (Complete with 15 working days): Date assigned: \_\_\_\_\_ Due Date: \_\_\_\_\_

Interviewed by: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Division Head Approval:  
Staff Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date Returned to Inmate: \_\_\_\_\_

F. If dissatisfied, explain reasons for requesting a Second-Level Review, and submit for processing to the Health Care Appeals coordinator at your location within 15 days of receipt of response:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

**SECOND LEVEL:**  Granted  P. Granted  Denied  Other \_\_\_\_\_

G. REVIEWER'S ACTION (Complete with 10 working days): Date assigned: \_\_\_\_\_ Due Date: \_\_\_\_\_

See Attached Letter

Signature: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

Health Care Services  
Hiring Authority Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date Returned to Inmate: \_\_\_\_\_

H. If dissatisfied, add data or reasons for requesting a Director's Level Review, and submit by mail to the third level within 15 days of receipt of response.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

For the Director's Review of Health Care issues, submit all documents to: Office of Third Level Appeals – Health Care  
P O Box 4038  
Sacramento, CA 95812-4038

**DIRECTOR'S ACTION:**  Granted  P. Granted  Denied  Other \_\_\_\_\_

See Attached Letter

Date: \_\_\_\_\_