STATE OF CALIFORNIA

DEPARTMENT OF CORRECTIONS AND REHABILITATION

PATIENT/INMATE HEALTH CARE APPEAL

CDCR 602 HC (REV. 04/11)

Side 1

STAFF USE ONLY	Institution:	Log #:	Category:
Emergency Appeal ☐ Yes ☐ No			
Signature: Date:	*FOR STAFF USE ONLY*		

You may appeal any California Prison Health Care Services (CPHCS) decision, action, condition, omission, policy or regulation that has a material adverse effect upon your welfare. See California Code of Regulations, Title 15, Section (CCR) 3084.1. You must send this appeal and any supporting documents to the Health Care Appeals Coordinator (HCAC) within 30 calendar days of the event that lead to the filing of this appeal. If additional space is needed, only one CDCR Form 602-A will be accepted. Refer to CCR 3084 for further guidance with the appeal process. No reprisals will be taken for using the appeal process.

Appeal is subject to rejection if one row of text per line is exceeded. **WRITE, PRINT, or TYPE CLEARLY.**

Name (Last, First):	CDC Number:	Unit/Cell Number:	Assignment:

State briefly the subject/purpose of your appeal (Example: Medication, To See Specialist, etc.):

A. Explain your issue (If you need more space, use Section A of the CDCR 602-A):

B. Action requested (If you need more space, use Section B of the CDCR 602-A):

☐ **Supporting Documents: Refer to CCR 3084.3.**

List supporting documents attached (e.g. Trust Account Statement; CDCR 7410, Comprehensive Accommodation Chrono; CDCR 7362, Request for Health Care Services; etc.):

☐ No, I have not attached any supporting documents. Reason :

Patient/Inmate Signature: **Date Submitted:**

☐ **By placing my initials in this box, I waive my right to receive an interview.**

STAFF USE ONLY

C. First Level - Staff Use Only

Staff – Check One: Is CDCR 602-A Attached? ☐ Yes ☐ No

This appeal has been:

☐ Bypassed at the First Level of Review. Go to Section E.

☐ Rejected (See attached letter for instruction) : Date: Date: Date: Date:

☐ Cancelled (See attached letter): Date:

☐ Accepted at the First Level of Review

Assigned to: Title: Date Assigned: Date Due:

First Level Responder: Complete a First Level response. Include Interviewer's name, title, interview date, location, and complete the section below.

Date of Interview: Interview Location:

Your appeal issue is: ☐ Granted ☐ Granted in part ☐ Denied ☐ Other:

See attached letter. If dissatisfied with First Level response, complete Section D.

Interviewer: (Print Name) Title: Signature: Date completed:

Reviewer: (Print Name) Title: Signature:

Date received by HCAC:

HCAC Use Only

Date mailed/delivered to appellant: ___/___/___

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Side 2

D. If you are dissatisfied with the First Level response, explain the reason below, attach supporting documents and submit to the Health Care Appeals Coordinator for processing within 30 calendar days of receipt of response. If you need more space, use Section D of the CDCR 602-A.

Patient/Inmate Signature: _____ **Date Submitted:** _____

E. Second Level - Staff Use Only **Staff – Check One: Is CDCR 602-A Attached?** ☐ Yes ☐ No

This appeal has been:

☐ By-passed at Second Level of Review. Go to Section G.

☐ Rejected (See attached letter for instruction): Date: _____ Date: _____ Date: _____ Date: _____

☐ Cancelled (See attached letter): Date: _____

☐ **Accepted at the Second Level of Review**

Assigned to: _____ Title: _____ Date Assigned: _____ Date Due: _____

Second Level Responder: Complete a Second Level response. Include Interviewer's name, title, interview date, location, and complete the section below.

Date of Interview: _____ Interview Location: _____

Your appeal issue is: ☐ Granted ☐ Granted in part ☐ Denied ☐ Other: _____

See attached letter. If dissatisfied with Second Level response, complete Section D.

Interviewer: _____ (Print Name) Title: _____ Signature: _____ Date completed: _____

Reviewer: _____ (Print Name) Title: _____ Signature: _____

Date received by HCAC: _____

HCAC Use Only
Date mailed/delivered to appellant: ___/___/___

F. If you are dissatisfied with the Second Level response, explain reason below; attach supporting documents and submit by mail for Third Level Review. It must be received within 30 calendar days of receipt of prior response. Mail to: Chief, Office of Third Level Appeals – Health Care, California Prison Health Care Services, P.O. Box 4038, 660 Suite 400, Sacramento, CA 95812-4038. If you need more space, use Section F of the CDCR 602-A.

Patient/Inmate Signature: _____ **Date Submitted:** _____

G. Third Level - Staff Use Only

☐ Rejected (See attached letter for instruction): Date: _____ Date: _____ Date: _____ Date: _____

☐ **Cancelled (See attached letter):** Date: _____

☐ Accepted at the Third Level of Review

Your appeal is ☐ Granted ☐ Granted in part ☐ Denied ☐ Other: _____

See attached Third Level response.

Third Level Use Only
Date mailed/delivered to appellant: ___/___/___

Request to Withdraw Appeal: I request that this appeal be withdrawn from further review because; State reason. (If withdrawal is conditional, list conditions.)

Patient/Inmate Signature: _____ **Date Submitted:** _____

Print Staff Name: _____ **Title:** _____ Signature: _____ Date: _____