PATIENT/INMATE HEALTH CARE APPEAL
CDCR 602-HG (REV. 04/11)

STAFF USE ONLY
Emergency Appeal: [ ] Yes  [ ] No
Signature: ___________________________ Date: ____________

Institution: ___________________________ Log #: ___________________________
Category: ___________________________

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 3094 for further guidance with the appeal process. No reprints will be taken for using the appeal process.

Rewrite, Print, or Type Clearly.

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 Chromo; 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.

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 instructions): 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: ____________________________ Title: ____________ Signature: ____________________________ Date completed: ____________

Reviewer: ____________________________ Title: ____________ Signature: ____________________________

(Print Name)

Date received by HCAC: ____________

HCAC Use Only
Date mailed/delivered to appellant: ____________
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.

E. Second Level - Staff Use Only

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

This appeal has been:
□ Rejected (See attached letter for instruction): Date: 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: Title: Signature: Date completed:

Reviewer: Title: Signature:

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, 600 Suite 400, Sacramento, CA 95812-4038. If you need more space, use Section F of the CDCR 602-A.

G. Third Level - Staff Use Only

□ Rejected (See attached letter for instruction): Date: 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.)

Print Staff Name: Title: Signature: Date: