STATE OF CALIFORNIA

HEALTH CARE GRIEVANCE

CDCR 602 HC (Rev. 06/17)

DEPARTMENT OF CORRECTIONS AND REHABILITATION

STAFF USE ONLY Expedited? ☐ Yes ☐ No Institution: Tracking #:

Staff Name and Title (Print) Signature Date

If you think you have a medical, mental health or dental emergency, notify staff immediately. If additional space is needed, only one CDCR 602 HC A Health Care Grievance Attachment will be accepted. You must submit this health care grievance to the Health Care Grievance Office for processing. Refer to California Code of Regulations (CCR), Title 15, Section 3087 for further guidance with the health care grievance process.

Do not exceed more than one row of text per line. WRITE, PRINT, or TYPE CLEARLY in black or blue ink.

Name (Last, First, MI):	CDCR #:	Unit/Cell #:

SECTION A: **Explain the** decision, action, condition, omission, policy, or regulation that has had a material adverse effect upon your health and welfare for which you seek administrative remedy.

If you need more space, use Section A of the CDCR 602 HC A

☐ **Supporting Documents: Refer to CCR 3087.2.** List supporting documents attached:

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

Grievant Signature: **Date Submitted:**

BY PLACING MY INITIALS IN THIS BOX, I REQUEST TO RECEIVE AN INTERVIEW AT THE INSTITUTIONAL LEVEL.

HEALTH CARE GRIEVANCE REVIEW INSTITUTIONAL LEVEL: Staff Use Only Is a CDCR 602 HC A attached? ☐ Yes ☐ No

This grievance has been:

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

☐ Withdrawn (see section C)

☐ Accepted Assigned To: Title: Date Assigned: Date Due:

Interview Conducted? ☐ Yes ☐ No Date of Interview: Interview Location:

Interviewer Name and Title (print): Signature: Date:

Reviewing Authority Name and Title (print): Signature: Date:

Disposition: See attached letter ☐ Intervention ☐ No Further Intervention ☐ No Intervention

If dissatisfied with Institutional Level Response, complete Section B.

HCGO Use Only: Date closed and mailed/delivered to grievant:

1. Disability Code:
☐ TABE score ≤ 4.0
☐ DPH ☐ DPV ☐ LD
☐ DPS ☐ DNH
☐ DDP
☐ Not Applicable

2. Accommodation:
☐ Additional time
☐ Equipment ☐ SLI
☐ Louder ☐ Slower
☐ Basic ☐ Transcribe
☐ Other*

3. Effective Communication:
☐ Patient asked questions
☐ Patient summed information
Please check one:
☐ Not reached* ☐ Reached
*See chrono/notes

4. Comments:

STAFF USE ONLY

Tracking #:

SECTION B:	**Health Care Grievance Appeal. If you are dissatisfied with the Institutional Level Grievance Response**, explain the reason below (if more space is needed, use Section B of the CDCR 602 HC A), and submit the entire health care grievance package by mail for Headquarters' (HQ) Level health care grievance appeal review. Mail to: Health Care Correspondence and Appeals Branch, P.O. Box 588500, Elk Grove, CA 95758.

Grievant Signature:	**Date Submitted:**

HEALTH CARE GRIEVANCE APPEAL REVIEW HQ LEVEL: Staff Use Only Is a CDCR 602 HC A attached? ☐ Yes ☐ No

This grievance has been:

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

☐ Withdrawn (see section C)

☐ Accepted

Interview Conducted? ☐ Yes ☐ No Date of Interview: _____ Interview Location: _____

Interviewer Name and Title (print): _____ Signature: _____ Date: _____

Disposition: See attached letter ☐ Intervention ☐ No Further Intervention ☐ No Intervention

This decision exhausts your administrative remedies.

HQ Use Only: Date closed and mailed/delivered to grievant:

SECTION C:	**Grievant requests to WITHDRAW health care grievance:** I request that this health care grievance be withdrawn from further review. Reason:

Grievant Signature:	**Date Submitted:**

Staff Name and Title (Print):	**Signature:**	**Date:**

STAFF USE ONLY

Distribution: **Original** - Returned to grievant after completed; **Scanned Copy** - Health Care Appeals and Risk Tracking System 2.0 (Do not place in central file or health record)

HEALTH CARE GRIEVANCE ATTACHMENT

CDCR 602 HC A (06/17)

STAFF USE ONLY

Institution: Tracking #:

Attach this form to the CDCR 602 HC, Health Care Grievance, only if more space is needed. Only one CDCR 602 HC A may be used.
Do not exceed more than one row of text per line. WRITE, PRINT, or TYPE CLEARLY in black or blue ink.

Name (Last, First, MI):	CDCR Number:	Unit/Cell Number:

SECTION A: Continuation of CDCR 602 HC, Health Care Grievance, Section A only (Explain the decision, action, condition, omission, policy or regulation that has had a material adverse effect upon your health and welfare for which you seek administrative remedy) :

Grievant Signature: _____ **Date Submitted:** _____

SECTION B: Continuation of CDCR 602 HC, Health Care Grievance Appeal, Section B only (Dissatisfied with Health Care Grievance Response) :

Grievant Signature: _____ **Date Submitted:** _____

STAFF USE ONLY

Tracking #:

STAFF USE ONLY	**Grievants <u>do not write</u> in this area.** Grievance Interview Clarification: Document issue(s) clarified during interview

Staff Name and Title: _____

Signature: _____ **Date:** _____

STAFF USE ONLY

Distribution: Original - Returned to grievant after completed, **Scanned Copy -** Health Care Appeals and Risk Tracking System 2.0 (Do not place in central file or health record)