## GRIEVANCE FORM



# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

TTY (800) 735-2929 Cal Relay Dial 711 Speech to Speech (866) 288-1909

## **Behavioral Health Director**

Connie Mendoza-Peraza, LCSW (559) 673-3508 Toll free (888) 275-9779

Please ask receptionist about your right to free language assistance services as well as alternative formats of this brochure. If you have physical limitations, we will help you find available, appropriate and accessible

## MADERA COUNTY BEHAVIORAL HEALTH SERVICES CLIENT GRIEVANCE FORM

- Grievances may be filed using this form, writing a letter, or submitted verbally, in person or by telephone.
- For assistance completing this form or to verbally report a complaint, you may get help from your therapist, the Program Supervisor, or those listed on the back of this form.
- To submit this form or a letter, you may give it to the receptionist or return in a self-addressed envelope we provide.
- You may designate someone to act on your behalf.
- The grievance process is confidential and applicable privacy laws followed.
- Your services at Madera County Behavioral Health will NOT be affected or change in any way if you file a grievance.
- You will be kept informed of the status of your grievance.

Please print or write clearly.
Name: Date:
Birth Date:
Name of Legal Guardian if on behalf of a minor:
Relationship:
How may we contact you?   Mail Address:
Telephone/Number(s):
May we leave message?   Yes   No
Your Current Service Location(s):
☐ 7 <sup>th</sup> Street ☐ Pine Street ☐ Chowchilla ☐ Oakhurst ☐ NA
Write a description of the events-be as specific as possible
including full names of persons involved, witnesses (if any) and
dates and time of incidents. You may use additional paper.

Have you tried to resolve the issue before?   No Yes.
Describe what you tried and the outcome.
What would you like to have happen to resolve this grievance?
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The Quality Management (QM) Coordinator oversees the
resolution process ensuring your grievance is addressed in ninety
(90) calendar days. You or the QM Coordinator may request an
extension of the timeline up to 14 calendar days; a decision maker
is designated who is neutral and has clinical expertise; you must
sign release forms for persons involved in solving the grievance;
you may file an appeal for a State Fair Hearing if the process does
not meet the specified timelines or you are dissatisfied with the
outcome.

I understand that the Mental Health Plan staff will be authorized to contact any involved provider in order to resolve my grievance. The Mental Health Plan staff will also be authorized to discuss any and all information that shall be needed to evaluate and resolve this grievance.

Date

Signature of person completing Form

#### ORIGINAL TO QUALITY MANAGEMENT COORDINATOR

If you need assistance completing this form please contact:

#### **Quality Management Coordinator**

(559) 673-3508 (888) 275-9779

#### **Patients' Rights Advocate**

(559) 673-3508 x. 1311 (888) 275-9779

## **Compliance Officer**

(559) 673-3508 x 1311

#### **State Ombudsman**

(800) 896-4042 TTY (800) 896-2512

Email: MHOmbudsman@dhcs.ca.gov

Please return this completed form to the receptionist or mail in the self-addressed envelope to:

#### Madera County Behavioral Health Services

Mental Health Plan P.O. Box 1288 Madera, CA 93639