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. 1270
(888) 275-9779

Compliance Officer
(559) 673-3508 x 1270

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

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 Moreno-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 services.

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:_____ Birth Date_____ 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 ☐ 7th 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? _____

The Quality Management (QM) Coordinator oversees the resolution process ensuring your grievance is addressed within thirty (30) 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