If you need assistance with completing this form:

- You may ask any Mental Health Plan (MHP) staff to assist you.
- You may call the Patient's Rights Advocate at (559) 673-3508 ext. 1267.
- You may ask anyone to act on your behalf at any time.

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

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

Quality Management Coordinator
(559) 673-3508
(888) 275-9779

Patients' Rights Advocate
(559) 673-3508
(888) 275-9779

State Ombudsman
(800) 896-4042
TTY (800) 896-2512
Email: MHOmbudsman@dhcs.ca.gov

Behavioral Health Director
Dennis Koch, MPA
(559) 673-3508
Toll free (888) 275-9779

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

FORMAL MHSA ISSUE RESOLUTION FORM

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

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

FORMAL MHSA ISSUE RESOLUTION FORM

NOTE: Your current Madera County Behavioral Health Services will **NOT** be adversely affected in any way by filing an MHSA Issue Resolution Form. If you have an MHSA issue, please complete this form; seal, stamp, and mail it. You may designate someone to act on your behalf. You will be kept informed of the status of your MHSA Issue Resolution.

Please print or write clearly.

Date: ____________________ Name: ____

Name of Legal Guardian if on behalf of a Minor: ________________________________

Address: ____

May we send mail to you at this address? *Yes* ☐ or *No* ☐

Telephone Number (Please indicate best time to call): _________________________

May we call you at this telephone number? *Yes* ☐ or *No* ☐

May we leave a message for you at this telephone number? *Yes* ☐ or *No* ☐

1. **Describe the reason(s) for requesting an MHSA planning or plan implementation resolution. Please be specific by including names, dates, and times whenever possible:**

Name: ______________________________ Date(s) of Incident(s): ____________________

Describe Issue: ____

____

____

____

2. Have you tried to resolve the problem(s) before requesting an MHSA planning or plan implementation issue resolution?

Yes ☐ Please describe what you have done to try to resolve the problem and include the results.

____

____

No ☐ I have not made any prior attempts to resolve the MHSA planning or plan implementation issue.

3. What would you like to see happen to resolve this MHSA planning or plan implementation issue?

____

____

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

________________________ ____

Today's Date Signature of person making request

FOR COUNTY USE ONLY

REVIEWED BY: ______________________________ **DATE:** ______________

RECOMMENDATIONS: ____

____