Tri-City Mental Health Center

Confidential Client Information
See Welfare and Institutions Code 5328
HIPAA, CFR 45, Parts 160 and 164

BENEFICIARY / CLIENT GRIEVANCE OR APPEAL FORM

YOU CAN FILE A GRIEVANCE AT ANY TIME

You may file a grievance or authorize another person to act on your behalf. You will not be subject to discrimination or any other penalty for filing a grievance. Your confidentiality will be protected at all times.

PERSON FILING THE GRIEVANCE OR APPEAL

Last Name	*First Name*	*M.I.*	*Medi-Cal #*	*Home Phone #*

Address	*Apt. #*	*City*	*State*	*Zip Code*

GRIEVANCE OR APPEAL FILED ABOUT

Name of Provider Staff	*Phone #*

Address	*Suite #*	*City*	*State*	*Zip Code*

In the space provided below, please describe in detail your grievance as completely and clearly as possible. If more space is needed, continue the description on the back of this form. Include the following information:

A. Date of the incident.
B. Detailed explanation of the incident.
C. Name of the staff person(s) involved and their relationship to you.
D. Names(s) and telephone number(s) of person(s) who witnessed the incident.
E. Any supporting documents you have. Be sure to sign and date them.

DESCRIPTION OF GRIEVANCE OR APPEAL: *(Please submit any supporting written documents with the grievance or appeal.)*

Your signature, or your personal representative's signature, gives Tri-City Mental Health Center consent to investigate your grievance or appeal. Following completion, please submit form to Reception.

Client's Signature _____ Date _____

Representative's Signature * _____ Date _____

**** If signed by client's personal representative, state relationship and authority to do so in the space provided below:***

_____

FOR OFFICE USE ONLY

Log Number: _____

Date Received by Complaint (QI) Dept: _____

Type of Complaint: ☐ Privacy ☐ Staff ☐ Facility ☐ Quality of Care ☐ Quality of Services

Referred to Privacy Officer? ☐ Yes ☐ No Date Referred *(if applicable)*: _____

Date Routed to Program Chief: _____

If Appeal, Date Routed to Executive Director: _____

BENEFICIARY / CLIENT GRIEVANCE OR APPEAL FORM

DESCRIPTION OF GRIEVANCE OR APPEAL – *CONTINUED FROM SIDE 1*

Information to include the following information *(along with any supporting written documents)*:

A. Date of the incident.
B. Detailed explanation of the incident.
C. Name of the staff person(s) involved and their relationship to you.
D. Names(s) and telephone number(s) of person(s) who witnessed the incident.
E. Any supporting documents you have. Be sure to sign and date them.