TRI-CITY Mental Health

Grievance/Appeal Issue Resolution Form

To file a grievance or appeal, please complete this form. Clients, participants, and stakeholders have a right to file a grievance or appeal and will NOT be subject to discrimination, retaliation, or any other penalty for filing. Please return completed grievance/appeal forms to the Compliance Office:

By Mail
Place your completed form in a sealed envelope and mail to:

Compliance Office-Confidential
Tri-City Mental Health
2008 N. Garey Avenue
Pomona, CA 91767

By Hand Delivery
Place your completed form in a sealed envelope and write: Attention Compliance Office – Confidential on the front, then take to the medical records desk/office at your Tri-City Clinic Location

By Email
Attach your completed form to an email and send to:

issueresolution@tricitymhs.org

A. Information about the person filing (grievant/appellant):

Name: ________________________________ Phone #: ____________________

☐ I am the Client/Participant ☐ I am the Authorized Representative of a Client/Participant
☐ I am a Stakeholder ☐ Other (please specify): ____________________________

B. Type of filing - (select only 1):

☐ Grievance (Can be filed anytime)

☐ Appeal – Standard
(Must be filed within 60 days of date on Notice of Adverse Benefit Determination - NOABD)

Enter Date of NOABD: ___________ and please include a copy of the Notice of Adverse Benefit Determination, with this form.

☐ Appeal – Expedited 72 Hour Decision
(Must be filed within 60 days of date on Notice of Adverse Benefit Determination - NOABD)

Please enter reason for expedited request (expedited appeals must qualify):

____

Enter Date of NOABD: ___________ and please include a copy of the Notice of Adverse Benefit Determination, with this form.

☐ Request for a Review of the Grievance Outcome
(Must be filed within 60 days of date on Grievance Outcome Notification)

Enter Grievance Reference #: ___________ [# is listed on outcome review notification letter]

☐ Request for a Review of the Appeal Outcome
(Must be filed within 60 days of date on Appeal Outcome Notification)

Enter Appeal Reference #: ___________ [# is listed on outcome review notification letter]

C. Information about the Client or Participant you are filing about:

Last Name:	First Name:
Date of Birth:	Phone #:

☐ Check here if this filing is not related to any client or participant; Then skip section C and continue in section D.

OFFICE USE ONLY	*Date Received by Compliance:*		*Reference #:*	
Category: ☐ Specialty Mental Health Services ☐ MHSA Programs and Services ☐ Stakeholder Process				
Type: ☐ Grievance ☐ Appeal ☐ Appeal-EXP ☐ Request for Review of-○Grievance-○Appeal				

D. Please describe the grievance/appeal:

Please describe the issue as complete and clear as possible. Please include any/all dates, times, programs, locations, and staff related to the issue.

How would you like to see this issue resolved?

Please attach additional sheets if more space is needed

E. <u>Signature of Grievant</u>:

I hereby request Tri-City Mental Health Authority to investigate the above grievance/appeal.

Signature of Grievant/Appellant **Date**

F. Authorization to Investigate Grievance/Appeal and o Use and Disclose Protected Health Information for the investigation.

I, the undersigned, authorize Tri-City Mental Health Authority to investigate the preceding grievance or appeal and herby authorize Tri-City Mental Health Authority (TCMHA) service providers and program/administrative staff members to disclose the following confidential and/or protected health information with the TCMHA Compliance Office for the purpose of investigating my Grievance or Appeal:

☑ **My past and current TCMHA treatment/services information and records.**
☑ **Other information relating to my grievance or appeal and/or denial or rights.**

This Authorization will expire on the date of the resolution of your Grievance or Appeal.

I understand that I have the right to refuse to sign the authorization to disclose protected health information, without affecting my ability to receive services.

I understand that this authorization can be revoked at any time, in writing, except to the extent that action has already been taken. If not earlier revoked, this authorization will terminate in one year. A copy of this authorization is of the same force and effect as the original.

If a legal representative is signing/co-signing, the medical decision-making authority of the legal representative must be verified. Additional proof of authority may be required.

❖ Signature of Client or Legal Representative:

Signature	**Print Name**	**Date**

Relationship of signer to client (check one):

Self-Client (18+) Parent (of Minor) Legal Guardian (of Minor) Conservator
Self - Minor Client (12-17) Guardian ad Litem/Legal Counsel for Minor

❖ Signature of Client or Legal Representative (only use if a second signer is required):

Signature	**Print Name**	**Date**

Relationship of signer to client (check one):

Self-Client (18+) Parent (of Minor) Legal Guardian (of Minor) Conservator
Self - Minor Client (12-17) Guardian ad Litem/Legal Counsel for Minor
Power of Attorney Qualified Relative Caregiver (with Affidavit)