CLIENT GRIEVANCES

FORM COMPLETION, PROCESSING, AND REPORTING

WHAT IS A GRIEVANCE

An individual's verbal or written expression of dissatisfaction about any matter other than a matter covered by a NOABD.

GRIEVANCE CATEGORIES

Access	• Service availability/access
Quality of Care	• Staff behavior/treatment concerns
Change of Provider	• Complaints associated with COP
Confidentiality	• Unauthorized/Improper release of information
Other	• Financial, Lost Property, Patients' Rights, etc.

CBO GRIEVANCE RESPONSIBILITIES

GRIEVANCE FILING AND REPORTING PROCESS

Complaint Made

- Offer the grievance form
- Offer assistance with the form
- Offer to resolve the grievance

GRIEVANCES: EXEMPT VS NON-EXEMPT

Exempt Grievances	Non-Exempt Grievances
Verbal/in-person grievances only	Grievance via physical mail
Resolved by the end of the next business day	Not resolved by the end of the next business day
Do not require full investigation by DHS-BHD QA staff	Require a full investigation by DHS-BHD QA staff

GRIEVANCES: REFERRED

Grievance not associated with a complaint about the contracted provider, or DHS-BHD

Not within the provider's jurisdiction to resolve

Refer the filer to the appropriate agency or department

GRIEVANCE / APPEAL / EXPEDITED APPEAL FORM

Today's Date: _____ ☐ Grievance ☐ Appeal ☐ Expedited Appeal

Name of Client: _____ Birthdate: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Email: _____

Name of legal guardian/conservator: _____

Name of services provider: _____

Person filing: _____ Phone: _____

Do you have Medi-Cal? ☐ Y ☐ N

Optional: I authorize the following person to act on my behalf in pursuing this grievance or appeal*

Name: _____ Relationship to Client: _____

** Authorization for Release of Protected Health Information (MHS 102) required.*

PLEASE PRINT CLEARLY. BE SPECIFIC BY GIVING NAMES, DATES, AND TIMES WHENEVER POSSIBLE. (attach additional sheets if needed)

1. Please describe the issue. _____

2. Please explain how you have tried to resolve the issue. _____

3. What would you consider a proper solution to this issue? _____

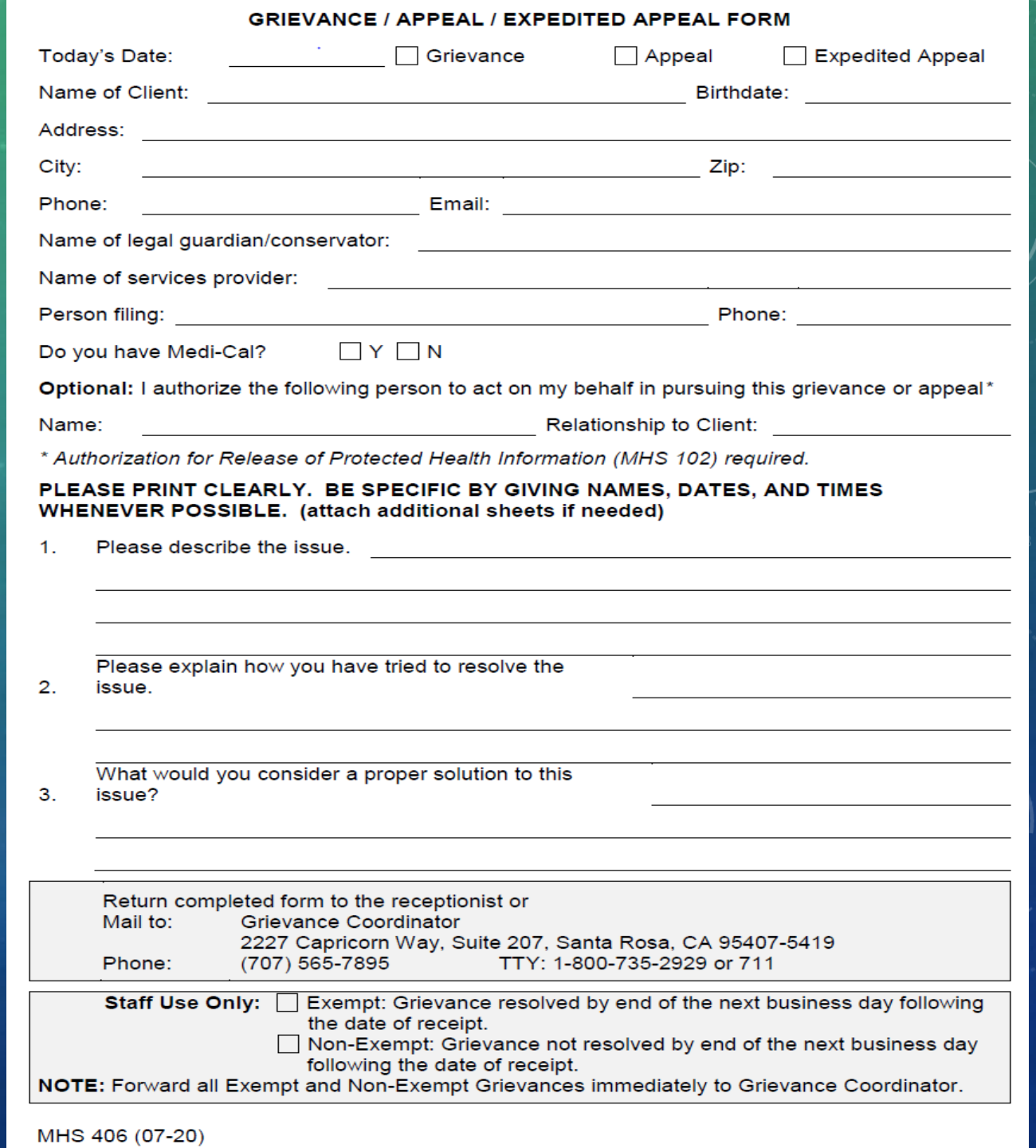
Return completed form to the receptionist or
Mail to: Grievance Coordinator
2227 Capricorn Way, Suite 207, Santa Rosa, CA 95407-5419
Phone: (707) 565-7895 TTY: 1-800-735-2929 or 711

Staff Use Only: ☐ Exempt: Grievance resolved by end of the next business day following the date of receipt.
☐ Non-Exempt: Grievance not resolved by end of the next business day following the date of receipt.

NOTE: Forward all Exempt and Non-Exempt Grievances immediately to Grievance Coordinator.

FORM COMPLETION - EXEMPT

- Mark the “grievance” box at the top of the form.
- In Section 3 indicate what action was taken by the provider to resolve the grievance.
- In the Staff Use Only Section Check the “Exempt” box
- Note the date the grievance was resolved
- Send the completed form to the DHS-BHD Grievance Coordinator immediately



GRIEVANCE / APPEAL / EXPEDITED APPEAL FORM

Today's Date: _____ ☐ Grievance ☐ Appeal ☐ Expedited Appeal

Name of Client: _____ Birthdate: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Email: _____

Name of legal guardian/conservator: _____

Name of services provider: _____

Person filing: _____ Phone: _____

Do you have Medi-Cal? ☐ Y ☐ N

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1. Please describe the issue. _____

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3. What would you consider a proper solution to this issue? _____

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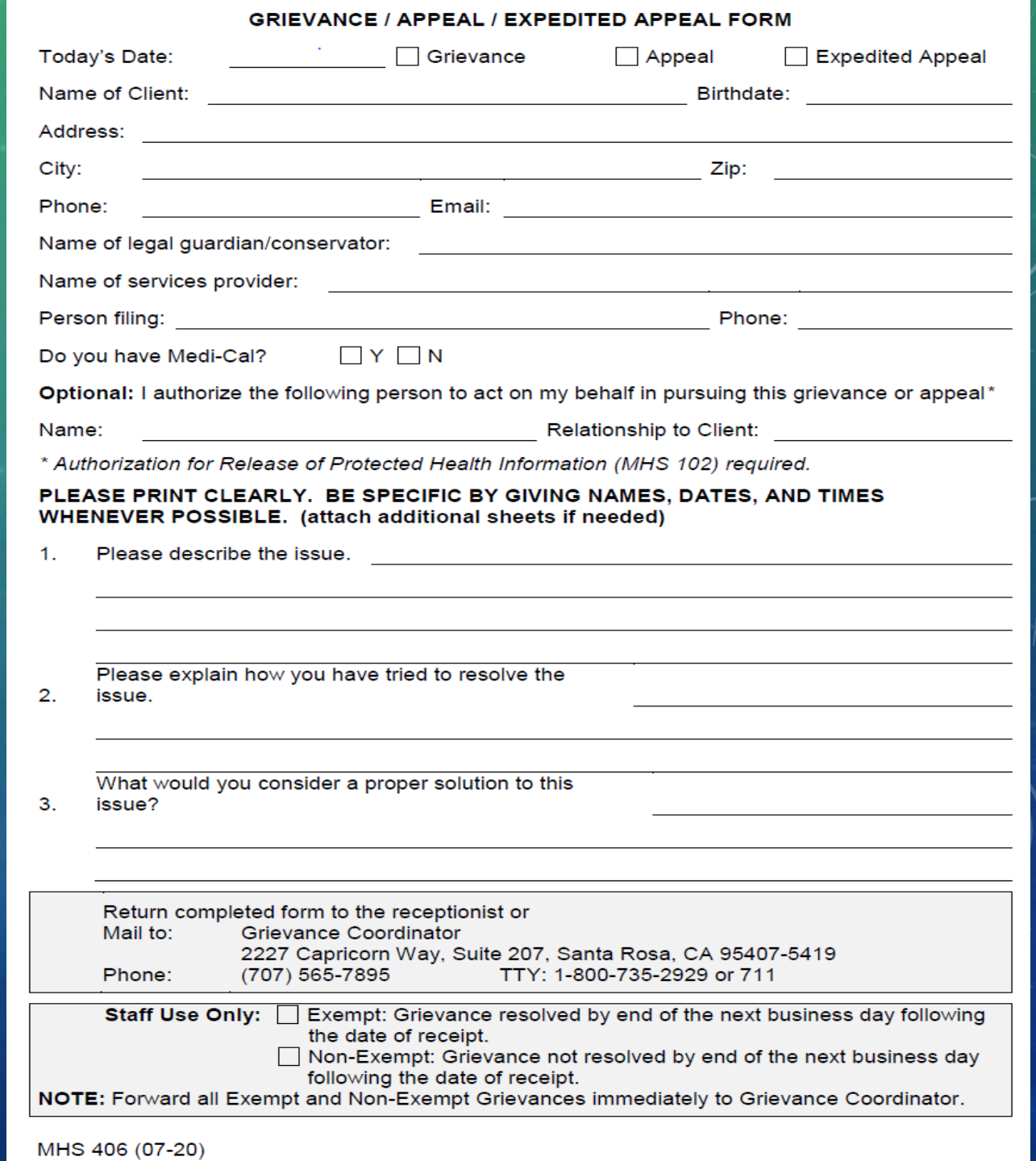
MHS 406 (07-20)

FORM COMPLETION – NON-EXEMPT

- Mark the “grievance” box at the top of the form.
- In Section 3 indicate what action was taken by the provider to resolve the grievance.
- In the Staff Use Only Section Check the “Non-Exempt” box
- Send the completed form to the DHS-BHD Grievance Coordinator immediately



GRIEVANCE / APPEAL / EXPEDITED APPEAL FORM

Today's Date: _____ ☐ Grievance ☐ Appeal ☐ Expedited Appeal

Name of Client: _____ Birthdate: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Email: _____

Name of legal guardian/conservator: _____

Name of services provider: _____

Person filing: _____ Phone: _____

Do you have Medi-Cal? ☐ Y ☐ N

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Name: _____ Relationship to Client: _____

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PLEASE PRINT CLEARLY. BE SPECIFIC BY GIVING NAMES, DATES, AND TIMES WHENEVER POSSIBLE. (attach additional sheets if needed)

1. Please describe the issue. _____

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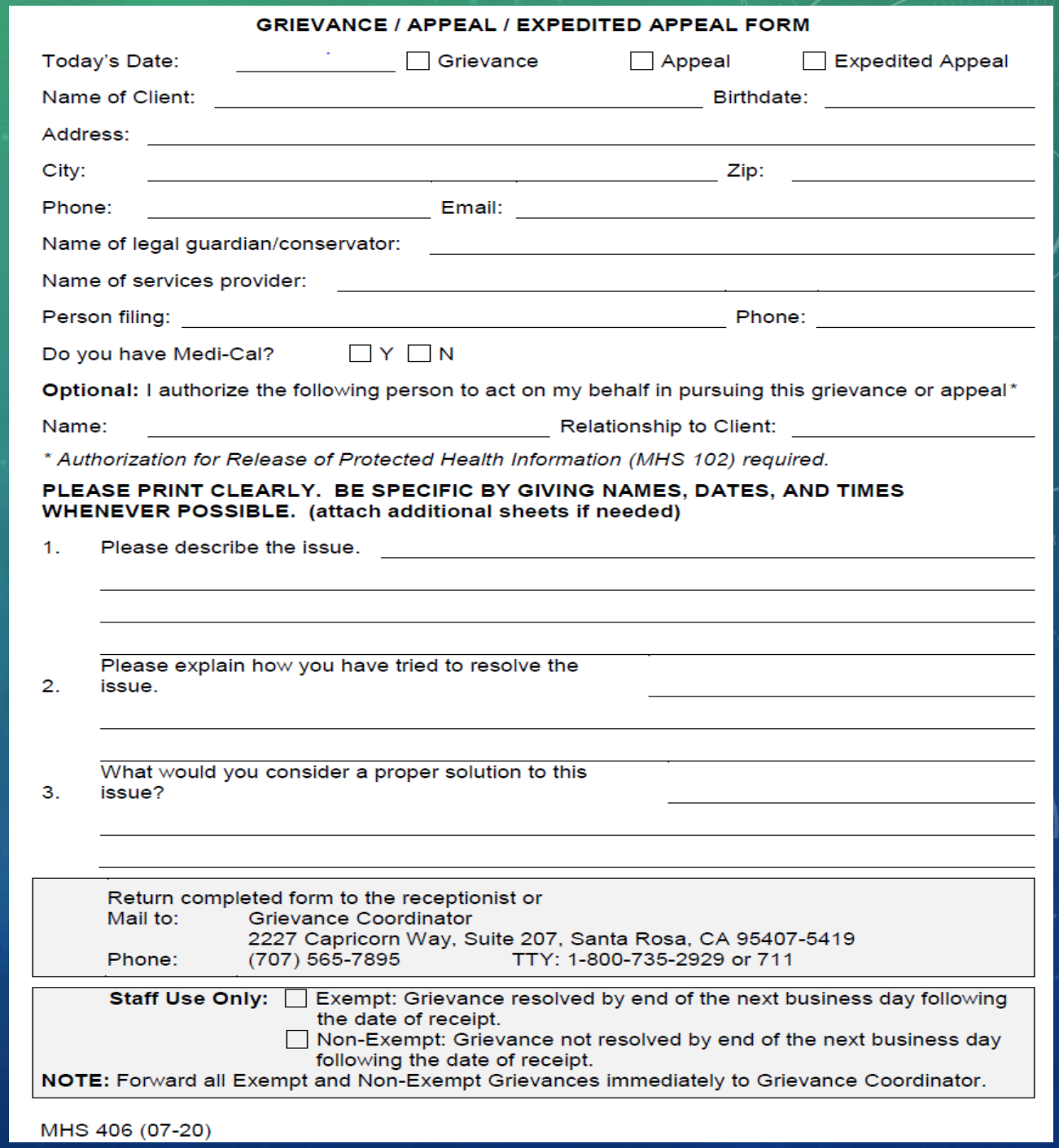
MHS 406 (07-20)

FORM COMPLETION – REFERRED

- Inform filer of referred status
- Mark the “grievance” box at the top of the form.
- In the Staff Use Only Section a. Check the “Exempt” box and write “***referred***”
- Note the date the grievance was referred and to whom.
- Send the completed form to the DHS-BHD Grievance Coordinator immediately



GRIEVANCE / APPEAL / EXPEDITED APPEAL FORM

Today's Date: _____ ☐ Grievance ☐ Appeal ☐ Expedited Appeal

Name of Client: _____ Birthdate: _____

Address: _____

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Phone: _____ Email: _____

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GRIEVANCE TRACKING & REPORTING

- Retain copies of all filed Grievances -immediately submit to the county the originals
- Develop and use a tracking method
- Complete and submit to DHS-BHD the Quarterly Grievances Report
- Use secure e-mail to send report and all Grievances to BHQA@sonoma-county.org

GRIEVANCE QUARTERLY REPORTING SCHEDULE

Quarterly Reporting Schedule		
Quarter Period		Report Due to SCBH
Quarter 1:	July 1- September 30	October 1
Quarter 2:	October 1- December 31	January 1
Quarter 3:	January 1- March 31	April 1
Quarter 4:	April 1- June 30	July 1
Submit Completed Report and All Supporting Documents (via secure e-mail) to: bhqa@sonoma-county.org		

GRIEVANCE QUARTERLY REPORT

Contracted Provider Name:							
GRIEVANCES							
CATEGORY	**REPORTING PERIOD**				**DISPOSTION**		
ACCESS	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Resolved Quarter 1	Referred Out Quarter 1	Pending Close of Quarter 1
Service Not Available							
Service Not Accessible							
Timeliness of Services							
24/7 Toll-free Access Line							
Linguistic Services							
Other Access Issues							
TOTAL	0	0	0	0	0	0	0
QUALITY OF CARE	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Resolved Quarter 1	Referred Out Quarter 1	Pending Close of Quarter 1
Staff Behavior Concerns							
Treatment Issues or Concerns							
Medication Concerns							
Cultural Appropriateness							
Other Quality of Care Issues							
TOTAL	0	0	0	0	0	0	0
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Resolved Quarter 1	Referred Out Quarter 1	Pending Close of Quarter 1
CHANGE OF PROVIDER							
TOTAL	0	0	0	0	0	0	0
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Resolved Quarter 1	Referred Out Quarter 1	Pending Close of Quarter 1
CONFIDENTIALITY CONCERN							
TOTAL	0	0	0	0	0	0	0
OTHER	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Resolved Quarter 1	Referred Out Quarter 1	Pending Close of Quarter 1
Financial							
Lost Property							
Operational							
Patients' Rights							
Peer behaviors							
Physical environment							
Other grievance not listed above							
TOTAL	0	0	0	0	0	0	0
GRAND TOTAL	0	0	0	0	0	0	0

GRIEVANCE FORM & SUBMITTAL

Grievance Form:

https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

Grievance Form Submittal:

BHQA@sonoma-county.org

GRIEVANCE CONTACT INFORMATION

QA Specialist – Christine Thomas

E-mail: Christine.Thomas@sonoma-county.org

Phone: 707-565-4848

Questions – Grievance receipt & resolution status

QA Manager– Katrina Suprise

E-mail: Katrina.Suprise@sonoma-county.org

Phone: 707-565-4733

Questions – Grievance requirements & procedure