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

	ay's Date:	•	Grievance	Appeal	Expedited Appea
Nar	ne of Client:			Birth	idate:
Add	ress:				
City	:			Zip	
Pho	ne:		Email:		
Nar	ne of legal gua	rdian/conservato	r:		
Nar	ne of services	provider:			
					none:
Do	you have Medi	-Cal?	/ 🗌 N		
Opt	ional: I author	ze the following	person to act on m	y behalf in pursuing	g this grievance or appeal
Nar	ne:		F	Relationship to Clier	nt:
* Aı	uthorization for	Release of Prote	cted Health Inform	ation (MHS 102) re	equired.
1.	Please desc	ribe the issue			
			tried to resolve the		
2.	Please expla issue.	in how you have		e	
 1. 2. 3. 	Please explaissue. What would issue? Return com Mail to:	in how you have you consider a p pleted form to the Grievance Coo 2227 Capricor	tried to resolve the roper solution to th e receptionist or ordinator n Way, Suite 207,	e	5407-5419

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		Expedited Appeal
				date:
Addı				
City:		· · · ·		
Pho		Email:		
Nam	ne of legal guardian/	conservator:		
Nam	ne of services provid	er:		
Pers	on filing:		Ph	one:
Do y	ou have Medi-Cal?	Y N		
Opti	ional: I authorize the	e following person to act on my	behalf in pursuing	this grievance or appeal*
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* Au	thorization for Relea	ase of Protected Health Informa	tion (MHS 102) re	quired.
				S, AND TIMES
		E. (attach additional sheets in	-	
1.	Please describe the	ne issue.		
	Please explain ho	w you have tried to resolve the	·	
2.	issue.			
	What would you c	onsider a proper solution to this		
3.	issue?			
	· · · · · ·	I form to the receptionist or evance Coordinator		
	222	27 Capricorn Way, Suite 207, S		
	Phone: (70	7) 565-7895 TTY: 1-	800-735-2929 or 7	711
	Staff Use Only:	Exempt: Grievance resolved the date of receipt.	d by end of the ne	xt business day following
		Non-Exempt: Grievance no		of the next business day
NOT	E: Forward all Exer	following the date of receipt npt and Non-Exempt Grievance		Grievance Coordinator
		ner and non Exemptionevalue		
MHS	6 406 (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

Name of Client: Birthdate: Address:	Name of Client: Birthdate: Address:					
Address:	Address:	-		Grievance		
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 Please explain how you have tried to resolve the 2. issue What would you consider a proper solution to this 3. issue? Return completed form to the receptionist or Mail to: Grievance Coordinator	City:	Name	of Client:		Birthda	ate:
Phone: Email: Name of legal guardian/conservator:	Phone: Email: Name of legal guardian/conservator:	Addre	ess:			
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Name:	Name:	Do yo	ou have Medi-C	Cal? 🗌 Y 🗌 N		
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Non-Exempt: Grievance not resolved by end of the next business day				Non-Exempt: Grievance n		f the next business day
		NOTE	: Forward all I			rievance Coordinator.
	MHS 406 (07-20)			•	-	

CRIEVANCE / APREAL / EXPEDITED APREAL FORM

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

Toda	y's Date: Grievance Appeal Expedited Appeal
	ess:
City:	Zip:
Phon	
	e of legal guardian/conservator:
	e of services provider:
	on filing: Phone:
Do yo	ou have Medi-Cal? □ Y □ N
Optio	onal: I authorize the following person to act on my behalf in pursuing this grievance or appeal*
Name	e: Relationship to Client:
* Aut	horization for Release of Protected Health Information (MHS 102) required.
	ASE PRINT CLEARLY. BE SPECIFIC BY GIVING NAMES, DATES, AND TIMES
WHE	NEVER POSSIBLE. (attach additional sheets if needed)
1.	Please describe the issue.
	Please explain how you have tried to resolve the
2.	issue.
	What would you consider a proper solution to this
З.	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.
NOT	E: Forward all Exempt and Non-Exempt Grievances immediately to Grievance Coordinator.
MHS	406 (07-20)

GRIEVANCE / APPEAL / EXPEDITED APPEAL FORM

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							
	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			IOD	DISPOSTION		
ACCESS		r	Quarter 3		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
CHANGE OF PROVIDER	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Resolved Quarter 1	Referred Out Quarter 1	Pending Close of Quarter 1
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: <u>https://sonomacounty.ca.gov/Health/Behavi</u> oral-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