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 Notice of Adverse Benefit Determination (NOABD).

How are beneficiaries informed of the Grievance Process?

All beneficiaries are informed of the Client Grievance process through the following informing materials located at DHS-BHD (MHP & DMC-ODS) provider sites:

a. The Beneficiary Handbook

b. Client Rights flyer

c. Client Rights and Grievance/Appeal Process and Form

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.
Discrimination Grievances	

Discrimination Grievance

Discrimination Grievance

"Discrimination Grievance" means a complaint concerning the unlawful discrimination on any characteristic protected under the federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Grievances Filed with BHP

1) Grievances can be filled by the client in the following ways:
- Verbally (Over the phone or In person)
- In writing (Email or mail)

2) Clinical Specialist logs the grievance & contacts the provider (via email) to notify that a grievance has been filed.
Clinical Specialist mails the client a formal acknowledgement letter, stating that the grievance is being investigated.

3) The provider & section manager work with the client to resolve the grievance
- The grievance must be resolved within 90 Calendar days of the filing date.

4) Once the resolution is resolved a formal resolution letter will be mailed
- The letter reviews the nature of the grievance, steps taken to resolve, and the final determination.

Note: If the provider is able to resolve (to the client's satisfaction) the grievance within the first business day, the grievance will be exempt from needing a full investigation, acknowledgement and resolution letter.

Grievances Filed with CBO

1) Client brings concern(s) to the provider

- Provider responds by offering a Grievance Form
- Offer to assist in the completion of the form
- Offer to resolve the grievance
- Completed form sent securely to Clinical Specialists

2) If Grievance is resolved within one business day of filing – Exempt

- Completed Grievance Form securely forwarded to Clinical Specialists

3) If Grievance is not resolved within one business day of filing – Non-Exempt

- Clinical specialists sends formal grievance acknowledgement letter to client
- Formal grievance investigation begins
- Clinical specialists coordinates with CBO to ensure timely resolution of grievance (within 90 days of filing)

4) Grievance Coordinators will send Non-Exempt Resolution Letter once investigation completed

- No Resolution Letter is Exempt Grievance

Grievance

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

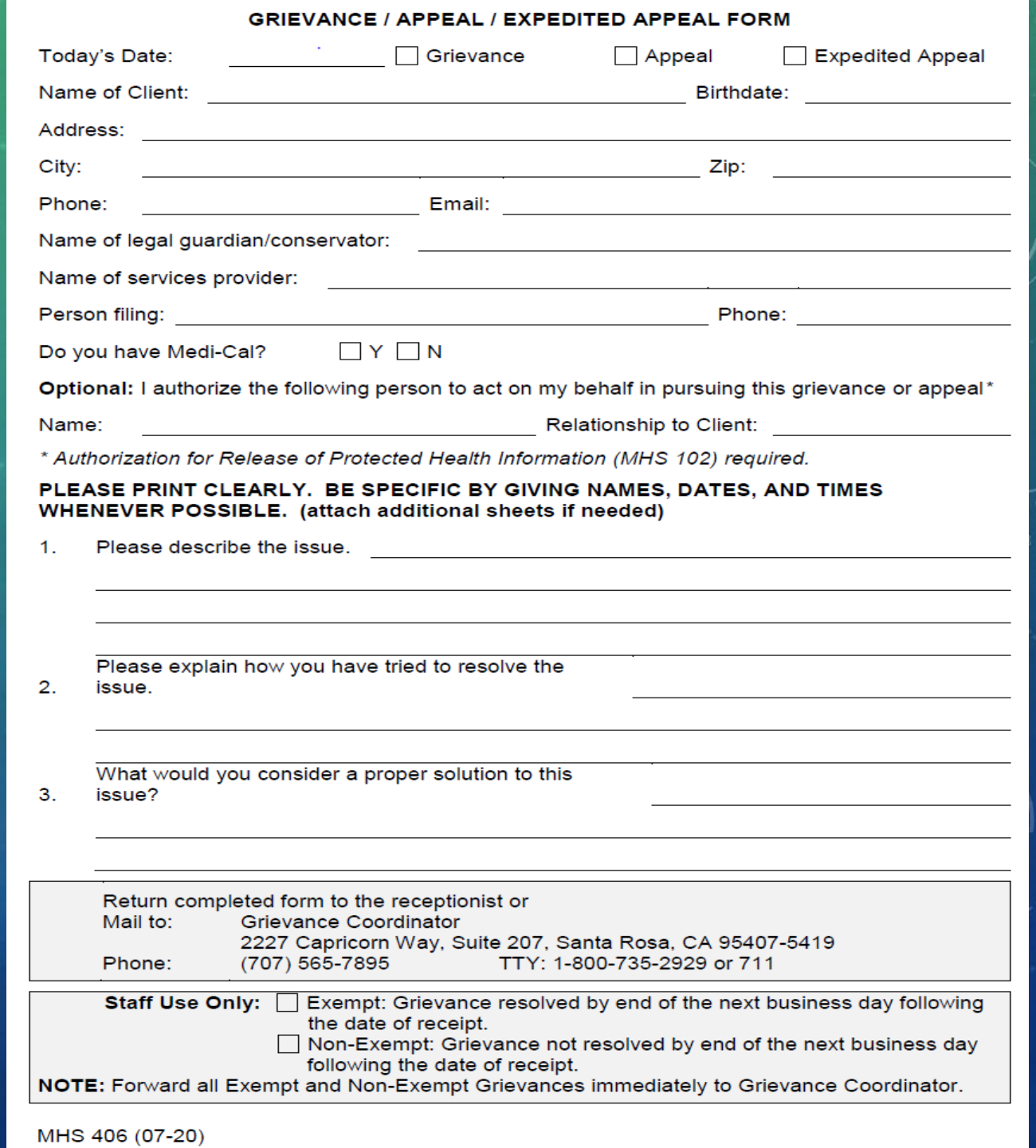
Staff Use Only: ☐ Exempt: Grievance resolved by end of the next business day following the date of receipt.
☐ Non-Exempt: Grievance not resolved by end of the next business day following the date of receipt.

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

MHS 406 (07-20)

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

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

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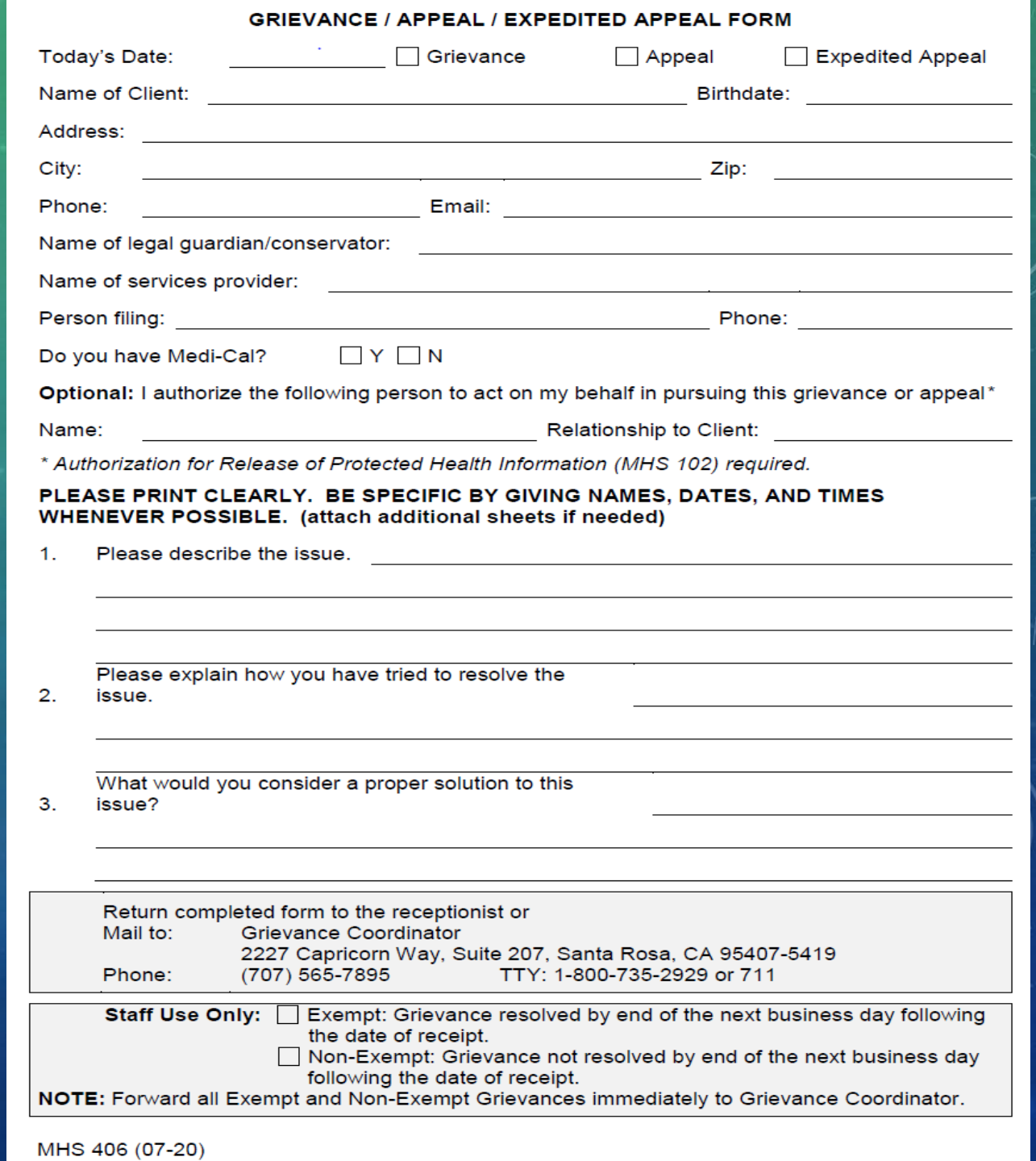
FORM COMPLETION – NON-EXEMPT

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

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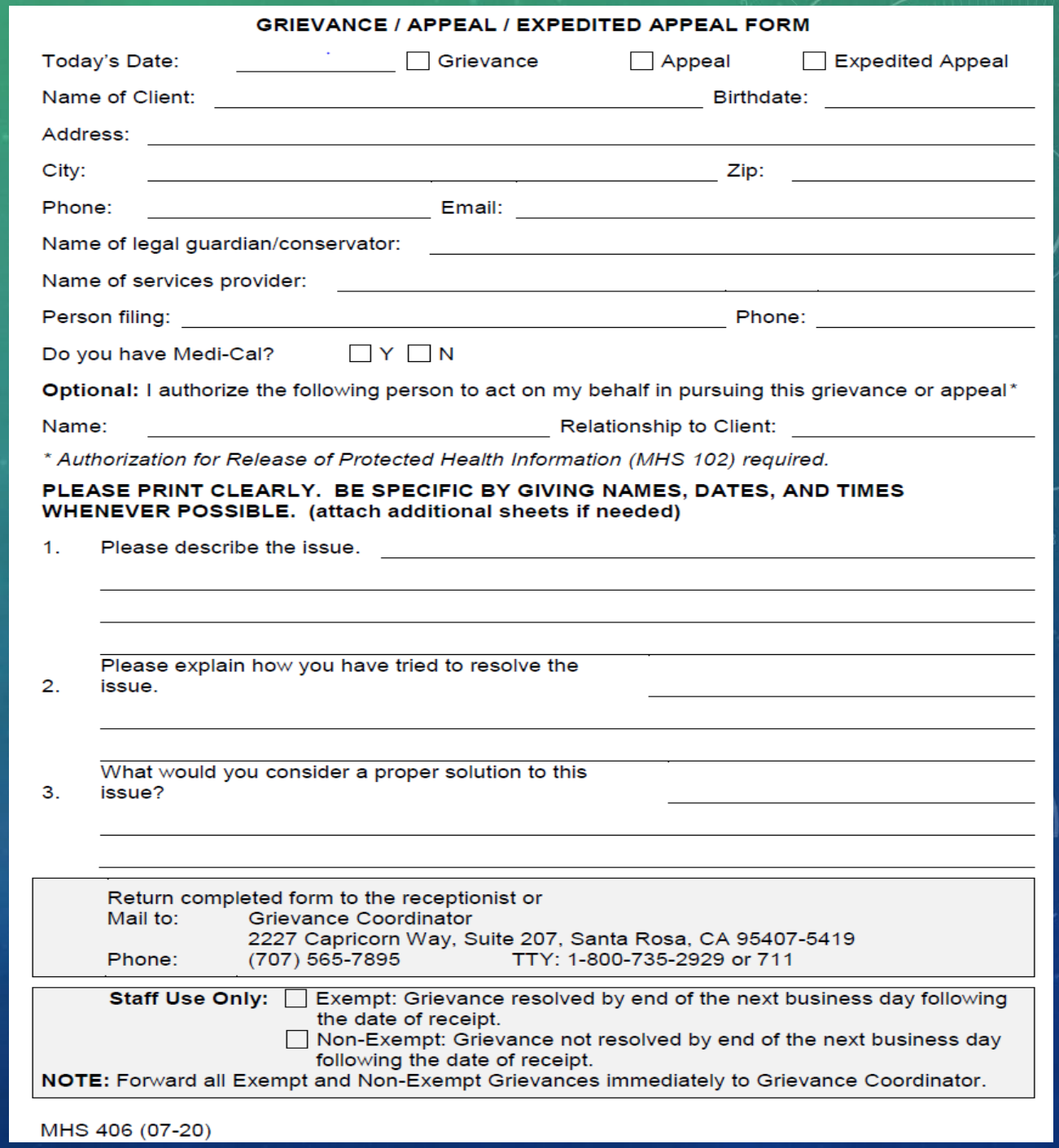
FORM COMPLETION – REFERRED

- 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: _____

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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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 TRACKING & REPORTING

- Retain copies of all filed Grievances- Immediately submit grievance to the County via email
- 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
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
CONFIDENTIALITY CONCERN	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
OTHER	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Resolved Quarter 1	Referred Out Quarter 1	Pending Close of Quarter 1
Financial							
Lost Property							

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 – Katie Gustafson

E-mail: Katie.Gustafson@sonoma-county.org

Phone: 707-565-4904

Questions – Grievance receipt, resolution status, requirements & procedure

QA Specialist– Trisha Sheldon

E-mail: Trisha.Sheldon@sonoma-county.org

Phone: 707-565-5129

Questions – Grievance receipt, resolution status, requirements & procedure