Tri~City
Mental Health Center

Beneficiary / Client Problem Solution Guide

Provider: **Tri-City Mental Health Center**
Address: **2008 N. Garey Avenue**
Pomona, CA 91767-2722

Complaint/Grievance Hotline: **(909) 784-3185**

Informal Complaint Process

1. Tri-City Mental Health encourages you to speak to the person you are having a problem with. Staff is aware that quality services are part of Tri-City Mental Health Center's mission and will attempt to solve problems directly with you.

2. If the problem cannot be solved with the staff person involved, or you feel uncomfortable speaking directly with the person, please ask to speak with the staff person's supervisor or ask to speak to Tri-City's Complaint Representative.

3. If you need help in addressing your problem, Tri-City can assign a staff person, with whom you feel comfortable, to help you. You may also get a family member to help you. Finally, you may also ask Tri-City's Complaint Representative to help you.

4. If your problem does not get resolved at this level, you may file a Formal Grievance as described in the next section.

Formal Grievance and Appeal Process

1. If you do not get your problems solved with the Informal Complaint Process, a Formal Grievance Process is available to you. You may file a grievance orally or in writing at any time.

2. To start the Grievance Process, you will need to fill out a Beneficiary/Client Grievance Form (please ask the receptionist or any staff member for the form). You may choose to include any supplemental information that you think would help your case. If you need assistance with completing the form and/or going through the Formal Grievance Process, please choose a family member, friend, Tri-City staff member, or the Complaint Representative to help you. You may need to complete an Authorization for the Release/Disclosure Form at this time so that we can investigate your grievance.

3. The forms will be submitted to the Complaint Representative. The Complaint Representative will log the grievance and provide the client with written receipt of the verbal or written complaint within **1 working day.** The Complaint Representative will coordinate with the Clinical Program Chief throughout the complaint process and monitor progress to ensure final resolution.

4. Complaints/ Grievances must be resolved within 60 calendar days from the date the complaint/grievance is filed with the Complaint Representative. This time frame may be extended by up to another 14 days in certain circumstances.

5. You will be notified of a course of action on solving the problem and will be informed of this decision in writing, by phone, or in person.

6. If you are not satisfied with the decision that has been made, you may ask to appeal your complaint to the Executive Director. You will need to submit the appeal in writing and include your signature. Standard appeals must be resolved within 45 calendar days of receipt of appeal. This time frame may be extended by up to another 14 days in certain circumstances. If you believe that waiting 45 days will put your health at risk, you should ask for an expedited appeal. The time frame for an expedited appeal is 3 working days.

7. If you are not satisfied following the appeal decision and you are a Medi-Cal recipient, you may ask for a State Fair Hearing if you think a service has been unfairly denied, reduced, or terminated. A State Fair Hearing is an independent review conducted by the State Department of Social Services. The hearing process ensures that a Medi-Cal recipient is receiving mental health services he/she is entitled to receive as a Medi-Cal beneficiary. To request a State Fair Hearing on your own, call 1-800-952-5253 or write to:

Administrative Adjudications Division
State Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814

If you are deaf and use TDD, call 1-800-952-8349

Rights of Clients of Tri-City Mental Health Center

Each client of Tri-City Mental Health Center has the following rights:

1. To receive the best possible service regardless of race, color, sex or sexual preference, age, handicap, national origin, religious or political affiliation.

2. To be fully informed, prior to becoming a client, of the services available and related charges for services.

3. To be free to choose providers and to request change of providers.

4. To be assured confidentiality of records and to approve or refuse their release to any individual outside the agency, except as required by law.

5. To refuse services, including medication, to the extent permitted by law and to be informed of the consequences of such refusal.

6. To be free from all forms of sexual harassment and sexual contact from other clients, staff, or other individuals associated directly or indirectly with Tri-City Mental Health Center.

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: ______________________

Tri~City
Mental Health Center

Month / Year of: ________________________________

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.