COMMUNITY COUNSELING SOLUTIONS
GRIEVANCE AND APPEAL FORM

If you need assistance completing this form, you may contact any of our locations and request help from a staff member other than the person you are filing the grievance about. On the back of this form is a list of our locations and phone numbers.

Date:________________________________________________________

Name:________________________________________________________

Date of incident or denial:_______________________________________

Does this grievance involve an urgent situation that cannot wait?  ____Yes  ____No
If yes, state the reason:________________________________________

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Grievance:_______________________________________________________
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*Attach additional sheets if necessary.

What would you like to happen in this matter?_______________________
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Community Counseling Solutions Locations and Phone Numbers:

Heppner       541-676-9161  
Boardman      541-481-2911  
Condon        541-384-2666  
Fossil        541-763-2746  
Arlington     541-454-2223  
John Day      541-575-1466  

Oregon Health Authority Division phone number (State of Oregon)
503-945-5763

Disability Rights Oregon
1-800-452-1694

Greater Oregon Behavioral Health Inc. (GOBHI) – Managed Care Organization
541-298-2101

GRIEVANCE AND PROCEDURE:
Should a client become dissatisfied with treatment for any reason, a formal grievance may be submitted in writing to the Program Manager. The Program Manager will respond within three working days from receipt of the grievance. If the client is not satisfied with the results of the action, he/she may appeal to the Executive Director. The Executive Director will respond in writing to the client within five working days. If the client feels the issue has not been resolved to their satisfaction, the client may appeal to Community Counseling Solutions’ Advisory Board. If the results remain unsatisfactory to the client they may seek the assistance of the Mental Health Division.

Any questions concerning the information stated above should be addressed to the Program Manager, Community Counseling Solutions, P.O. Box 468, Heppner, OR 97836.

____________________________________
Signature
For Office Use Only

Date Complaint Received:__________________  Date of Follow Up:__________________

Resolution:

__________________________________________________________________________

__________________________________________________________________________

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__________________________________________________________________________
GRIEVANCE AND APPEAL FORM

If you need assistance completing this form, you may contact your Community Mental Health Provider (CMHP) and request help from a staff member other than the person you are filing a grievance about. If you do not want to file a grievance directly to the Mental Health Provider, you may direct it to Greater Oregon Behavioral Health, Inc. (GOBHI) by writing to 309 East Second Street, The Dalles, OR 97058 or calling 1-800-493-0040.

Date ___________________________ CMHP
Name ___________________________ OHP#
Date of incident or denial ___________________________

If denial of service, do you want your benefits to continue? _____Yes _____NO

Does this grievance involve an urgent situation that cannot wait? _____Yes _____No

If yes, state the reason ____________________________________________________________

Grievance: __________________________________________________________

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Attach additional sheets if necessary.

What would you like to have happen in this matter? __________________________________

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_____________________________________________________________________________

Signature: __________________________________________________________

_____________________________________________________________________________

OFFICE USE ONLY

Good Cause Exception: _____Yes _____No Explain: ____________________________________

_____________________________________________________________________________

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