Headquarters: 251 Llewellyn Avenue, Campbell, CA 95008 Phone (408) 379-3790 Fax (408) 364-4013

CUSTOMER AND FAMILY COMPLAINT GRIEVANCE FORM

This is a double-sided form

If you have any problems or complaints with your mental health services, or how the Agency has used your Protected Health Information, you may file a Formal Grievance at any time. However, we encourage you to discuss your complaint(s) directly with your service provider or a program representative whenever possible. Upon completion of this form, please submit for review and action to the Program Manager/Associate Director or mail to the address provided at the top of this form.

Please Print or Write Clearly

Your Name:_____ Phone:_____ Today's Date:_____/_____/_____
Person completing this form Person completing this form

Your Address: _____ City:_____ State: __CA_ Zip:_____

Youth/Customer Name: _____ DOB: _____/_____/_____

Your relationship to Youth/Customer: _____ Date of Incident: _____/_____/_____

Printed Name of Parent/Legal Guardian or Healthcare Representative: _____
If different from above

Name of service provider: _____ **Program:** _____

Location where you are receiving services: _____
Address of Agency's location

Describe the problem or issue, include dates and time period of problem: (Attach additional sheets if necessary):

_____

_____

_____

What have you already done to resolve this problem? _____

_____

How would you like to see this problem resolved? _____

_____

_____

Is this problem or issue related to use of your Personal Protected Health Information? ❑ Yes ❑ No

If yes, you may also contact DHHS Regional Office of Civil Rights at (800) 368-1019.

_____ _____/_____/_____
Signature of Youth/Customer, if age 12 or older Date

_____ _____/_____/_____
Signature of Parent/Legal Guardian/Healthcare Representative Relationship to Youth Date

Please return completed Grievance Form to the Program Manager/Associate Director where you are receiving services or mail Attention: Corporate Compliance Officer, Uplift Family Services, 251 Llewellyn Ave., Campbell, CA 95008. If you have any questions on completing this form please call (408) 364-4005.

FOR STAFF USE ONLY

PROGRAM SUPERVISOR / DIRECTOR SECTION

Page 2 – Grievance and Complaint Form

Received by: _____ Date Received: _____/_____/_____
Name of Uplift Family Services Staff Member

Name of Manager: _____ Phone: _____

Date given to Manager: _____/_____/_____ Program & Location:_____

Action Taken:_____

_____

_____

_____

Was complaint/grievance **resolved** or **unresolved:** _____ Date resolved/unresolved _____/_____/_____

If unresolved, forward a copy of this form to the Corporate Compliance Officer

If unresolved-give reason and action plan: _____

_____

_____

_____

Name of Supervisor/CPM: _____ Phone:_____

Signature of Supervisor / CPM: _____ Date Signed: _____/_____/_____

Comments:

_____

_____

_____

Name of Program/Associate Director: _____ Date copy received:_____/_____/_____

Signature of Program/Associate Director: _____ Date Signed: _____/_____/_____

Contact Phone Number:_____

- ✓ Date Copy sent to Corporate Compliance Officer:_____/_____/_____
- ✓ Date Forwarded to Regional Executive Director and Medical Director as pertinent: _____/_____/_____
- ✓ Date Copy forwarded to Privacy Officer as pertinent: _____/_____/_____