Deschutes County Health Services (DCHS)
Grievance Form

If you, your family, or authorized representative(s) have an issue with access, service, clinical care, contact with staff, quality of care, or your rights, please let us know. You shall not be subject to retaliation for filing a grievance or complaint.

Date of Grievance:

Name: **Phone #:**

Address:

Date of Birth:

DCHS Program: ACCESS

Staff Involved:

Describe the Grievance (provide details about concerns**):**

Signature of Person Completing Form: **Date:**

Return to one of the following: Your clinician, a supervisor, a manager, front desk staff, or to a quality improvement analyst. This form may be mailed to: Attention: CQA, 2577 NE Courtney Drive, Bend OR 97701. This form may be emailed to: healthservices@deschutes.org. Your clinician, their supervisor, or a Quality Improvement Analyst will contact you regarding your complaint/grievance. One of these individual will work with you to resolve your concerns. An investigation of any grievance shall be completed within thirty (30) calendar days.

FOR OFFICE USE ONLY

DCHS Grievance Review

Instructions: If this is resolved at the supervisor and/or manager level, staff shall fill out the information below for CCO and state reporting purposes. Once completed, submit to the designated Quality Improvement Analyst.

Date of Review:

Supervisor and/or Manager Name:

Identification of Direct Care and/or System Concerns:

Determination of Response and/or Action Plan:

Resolution:

Signature: **Date:**

Compliance and Quality Assurance (CQA) Review

Date Received:

Additional Follow-Up Required: ☐ Yes ☐ No

Comments: