MONO COUNTY BEHAVIORAL HEALTH, ALCOHOL AND DRUG PROGRAMS

COUNTY OF MONO

P.O. BOX 2619 ▪ MAMMOTH LAKES CA 93546 ▪ (760) 924-1740 FAX ▪ (760) 924-1741

PROBLEM RESOLUTION FORM

You will not be subject to discrimination or any other penalty for submitting this form.

Please check the box that applies to this request:

❑ Grievance ❑ Appeal ❑ Expedited Appeal ❑ State Fair Hearing

Please complete all information below (Please Print):

TODAY'S DATE: _____

If applicable, name of person assisting with the completion of this form:

_____

Name of person filing this grievance/appeal:

_____

Signature of person filing this grievance/appeal:

_____

Mailing Address: _____

_____

Phone Number: _____

DESCRIPTION OF PROBLEM - Please be as specific as possible by including dates, times, locations, individuals involved, etc. (please attach more pages if necessary):

_____

_____

_____

PLEASE STATE THE DESIRED SOLUTION OR REMEDY: _____

_____

_____

You may file a GRIEVANCE/APPEAL if you are unhappy with a decision or service, made regarding your mental health or substance use disorder (SUD) services here. If you received a Notice of Adverse Determination (NOABD), an APPEAL must be submitted within 60 calendar days of the original decision, and a verbal Appeal must be followed up in writing. Resolution of your Appeal may take up to 30 calendar days. If you are concerned that the length of time allowed for resolution of your Appeal may put your health at risk, you may request an Expedited Appeal. The timeframe for resolution of an Expedited Appeal is 72 hours.

You may authorize another person to act on your behalf. For complete information on filing Grievances and Appeals, please see the "*Notice of Problem Resolution Process*" or ask any staff person for assistance.

Mail or Deliver Problem Resolution Forms to:

Mono County Behavioral Health
PO Box 2619
1290 Tavern Road
Mammoth Lakes CA 93546
ATTN: Quality Assurance Coordinator

Phone Numbers:
MCBH Quality Assurance Coordinator or Director: 1-760-924-1740
Patients' Rights Advocate: 1-530-470-2722

*** FOR OFFICE USE ONLY ***

Form received by: Date received:

Category:
❑ Access ❑ NOAD/Denied Service ❑ Change of Provider ❑ Quality of Care
❑ Confidentiality ❑ Other:

_____

Follow up assigned to: Date:

Notifications: (Attach all documentation and file with original grievance/appeal form)
Acknowledge receipt of grievance/appeal: Date:
Staff signature: _____

Resolution to Individual: Date:
Staff signature: _____

Log entry made: Date:
Staff signature: _____

See Quality Improvement Committee (QIC) Minutes dated _____ (if applicable).

DISPOSITION:

_____