FAIR

District of Columbia Department of Behavioral Health
Consumer Grievance Procedure

Form A New Grievance

A

First Name	M.I.	Last Name	DOB	Male Female

Information Received by (Name) if applicable	Today's Date	Date Filed

Against ☐ MHA ☐ Provider	Provider Where Enrolled	Provider Filed Against

Mailing Address			
City	State	Zip	Email Address

Telephone 1 ☐ Leave Message OK	Telephone 2 ☐ Leave Message OK

How consumer prefers to be contacted: Tel. Write Email In Person	Individual Filed Against (If Any)	Does this grievance involve abuse & neglect or denial of service? ☐ Yes ☐ No

Is complaint about failure to comply with earlier grievance decision? ☐ Yes ☐ No	Subject Matter of Grievance (One required): Code 1	Code 2	Code 3

Summary of Grievance

What does consumer want done?

Please fill out page 2

Describe any previous attempt to resolve the problem:	
☐ Ind. Peer Advocate (C.A.N.)? If so, ID No. ☐	☐ Other Representative (Complete Form B)
The consumer should keep a copy of this form for their records.	

To the Consumer:

1. **A copy of this form is proof that you filed your grievance on the date above. Please keep your copy of the form until your grievance is over.**
2. **Information about your grievance that you provide, or that others provide, may be shared with staff of the Office of Consumer and Family Affairs and with others who respond to the grievance. Information about the grievance will NOT be placed in your clinical record or shared with anyone not involved in the grievance.**
3. **You cannot be punished or treated unfairly because you file a grievance.**

Consent to Representation

B

Representative's First Name	Representative's Last Name

Representative's Mailing Address

City	State	Zip	Telephone

Mailing Address and/or Email Address	Relationship to Consumer/Client (Circle One) FAMILY FRIEND CAN ULS OTHER

☐ I want you to speak **only** to my representative about settling the grievance, but send me copies of any written responses to the grievance.

☐ I want to be involved **by myself** in trying to settle the grievance, but send my representative copies of any written responses to the grievance.

☐ I want **us both** to be involved in the grievance. Send **us both** any written responses to the grievance.

_____ _____

Signature of Consumer/Client or Guardian Date

☐ Consumer/Client declined to sign this form.

Consumer/Client must sign Authorization to Disclose Form (DBH-HIPAA Form 3). Please give consumer copies of 1) Form A New Grievan e 2) Form B, Consent to Representation and 3) Authorization Form. Please staple the forms together.

To the Consumer/Client:

1. **A copy of this form is proof that you filed your grievance on the date above. Please keep your copy of the form until your grievance is over.**
2. **Information about your grievance that you provide, or that others provide, may be shared with staff of the Office of Consumer and Family Affairs and with others who respond to the grievance. Information about the grievance will NOT be placed in your clinical record or shared with anyone not involved in the grievance.**
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Form D **Provider Response/Appeal**

D

Consumer's/Client's Name	Response Delivered to Consumer/Client by	Notification Date to Consumer/ Client
Date of Original Grievance Level?	Response to Grievance from What ☐ Informal ☐ Provider CEO	Response is Dated

Text of Response or Outcome (Attach Additional Sheet if Necessary). Please **Specify** who **wrote** the response and worked on the problem and how. **Be Sure to Sign & Date!**

CONSUMER'S/CLIENT'S DECISION: I have decided to (check one)

☐ End my grievance now. No further action will be taken.

☐ Appeal my grievance to the next level. I and/or my Representative will be notified of my External Review (appeal) date.

☐ Wait to decide whether to appeal my grievance. I understand that if I want to appeal I must decide within (10) business days after the date of the response to my grievance.

For appeals to DBH for External Review:

- I am ___ am not ___ willing to meet in the same room with provider staff to discuss the grievance.
- I prefer (select one) ___ mediation, ___ a hearing, ___ no preference
  (Please note that the FAIR program will make the final decision).
- I need the following special accommodation: _____

_____

_____

_____ _____

Signature of Consumer/Client Date

Please provide a copy of this form to the consumer/client

Revised March 2014