



District of Columbia Department of Behavioral Health  
Consumer Grievance Procedure

Form A **New Grievance**



First Name	M.I.	Last Name	DOB	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Today's Date	Date Grievance Filed		Information Received by (Name)		
Against DBH <input type="checkbox"/>	- Provider <input type="checkbox"/>	Provider Where Enrolled	Provider Filed Against		
Mailing Address					
City	State	Zip	Email Address		
Telephone # <input type="checkbox"/>	Leave Message OK		How Consumer/Client prefers to be contacted: Tel.    Write    Email    In Person		
Is complaint about failure to comply with earlier grievance decision? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subject Matter of Grievance	Does this grievance involve abuse & neglect or denial of service? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Summary of Grievance (Attach additional sheet, if necessary)</b>					
<b>What does consumer/client want done?</b>					
<b>(Please Complete B as applicable )</b>					
<b>Describe any previous attempt to resolve the problem:</b>					

# 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 Grievance 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.
3. You cannot be punished or treated unfairly because you file a grievance.



District of Columbia Department of Behavioral Health  
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 Form D **Provider Response/Appeal**



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 <input type="checkbox"/> Informal <input type="checkbox"/> 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**

