

SEQUOIA

MENTAL HEALTH SERVICES, INC.

CLINICAL SERVICES INDIVIDUAL GRIEVANCE POLICY AND PROCEDURE

Policy:

Sequoia staff strives to provide the highest quality of mental health services. Persons receiving mental health services will be treated with respect and consideration. If, for any reason, an individual is not satisfied with the services or treatment received, Sequoia maintains a Quality Improvement system for individuals to make either formal or informal grievances pursuant to the Oregon Administrative Rule 309-019-0215. No retribution or adverse reaction will occur when an individual files a grievance.

Procedure:

Individuals are encouraged to address the issue at the most direct level possible, by talking first with their clinician, prescriber or other person involved with the incident. If an individual wishes to file a formal grievance request:

1. Please complete one of the grievance forms provided;
2. Address the form to the Clinical Director for review.

An investigation will be completed within 30 calendar days of the filing date. A response to a formal grievance will be made within five (5) working days of the conclusion of the investigation into that grievance. If the individual is not satisfied with the response provided, they may request further review by the Executive Director of the agency. The individual will receive a response within 10 working days of the second request for review.

If the individual or representative feel that health or safety are at risk, they may request an expedited process, and a program administrator will provide a written response within 48 hours of receipt. This response will include information about the appeals process.

Appeals Process:

If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the response to the grievance. The appeal must be submitted to the Washington County Mental Health Department. The County Mental Health Department must provide a written response within ten working days of the receipt of the appeal. If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the AMH Director.

*****If assistance is needed in submitting a grievance or appeal, it will be provided. *****

Clinical Director	503-591-9280	Executive Director	503-591-9280
Sequoia Mental Health	503-591-9280	Disability Rights Oregon	503-243-2081
Oregon Dept. of Human Service	503-945-5944	Washington County Mental Health	503-846-8881

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CLINICAL SERVICES INDIVIDUAL GRIEVANCE FORM

Date Submitted: _____

Name of person filing grievance: _____

Address: _____

Phone: _____

I am making the grievance against: _____

This grievance is addressed to: _____

Please explain why you are filing this grievance:

What outcome would you like? _____

(If you need more space for information, please attach another piece of paper)

Received on: _____ By: _____

Review/Findings Action Taken: _____

Staff use only.

Outcome Communicated: Phone Writing Date: _____ BY: _____

(Copies will be provided to: Client (as requested), Clinical Supervisor, QI, Clinical Director & Executive Director.)

Important Phone Numbers

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