Transitions-Mental Health Association

Client Grievance Form

This form may be used to document a Concern, Complaint or Grievance in all programs
Thank you for bringing this to TMHA's attention.

TMHA Program, if known: _____

For TMHA Programs in San Luis Obispo County, Grievances may also be filed with SLO County's Patients Rights advocate: (805) 781-4738.
For Community Care Licensing Programs, Grievances may also be filed with CCL 1-844-LET-US-NO (1-844-538-8766).
For TMHA Programs in Santa Barbara County, Grievances may also be filed with SB County's Patients Rights advocate: (805) 934-6548.

Date: _____

Name of Person completing this form: _____

Address: _____

Telephone Number: _____

Description of Complaint/Grievance: _____

File Path: T→ Employee Resources→ TMHA Grievance Forms→ TMHA Client Grievance Form

Client Grievance Form Continued

Action Requested: _____

_____

_____

_____

_____

_____

_____

_____

_____
Signature of Person Completing this Form

Submit this Form to any TMHA employee or office. Or mail to:

Transitions-Mental Health Association
Quality Assurance
PO Box 15408
San Luis Obispo, CA 93406

For Office Use:

Please follow TMHA Grievance Protocol.

Date Form Received: _____ **Employee Receiving Form:** _____

Name of Program Manager or Director notified: _____

Date of outreach to schedule a meeting: _____ **Date of Meeting:** _____

TMHA Staff: Please follow TMHA Grievance Protocol, and write a Resolution Summary: a brief written summary of the resolution of this grievance, signed by TMHA Director and the client. This Resolution Summary will be attached to this Griecance form and submitted to the TMHA Quality Assurance Specialist.