



FORMAL COMPLAINT PROCEDURE

If at any time you believe your rights have been denied, or you are displeased with the service you are receiving from LifeWorks NW, you have the right to file a complaint. You may also call and leave a verbal message on our Complaint and Grievance Line at 503-645-3581 X 2450. Your complaint will be kept confidential and will be addressed promptly. Filing a complaint will not result in denial of service or any other negative consequence. We recommend you discuss your complaint with the staff person involved. If you still feel your grievance has not been resolved, you may file a complaint in writing using this Formal Complaint Form. If you need assistance filling out the form, call the LifeWorks NW receptionist for help (503-645-3581) or ask the receptionist at the office where you receive services.

HOW TO FILE A COMPLAINT

Fill out the attached LifeWorks NW Formal Complaint Form as completely as possible.

Mail (or give) the completed form back to the receptionist.

You will be contacted within five working days by a supervisor to discuss your complaint. We hope your complaint can be resolved with this contact.

If you are an Oregon Health Plan member, you may also file a complaint directly with the mental health organization that manages your Oregon Health Plan benefits. Form OHP 3001 is also located in the lobby area, with directions on how to submit it.

HOW TO FILE AN APPEAL AND REQUEST A HEARING

It is our hope to resolve any complaint promptly and confidentially at the supervisor level. If you are dissatisfied with the plan to resolve your complaint, you may request an appeal hearing. We ask that you call the LifeWorks NW receptionist at 503-645-3581 and ask to have the Request For Appeal Form mailed to you.

Send the appeal request to the VP of Clinical Services at LifeWorks NW, 14600 NW Cornell Road, Portland, Oregon, 97229. The LifeWorks NW Complaint and Grievance Committee, chaired by the Clinical Director, will meet to review all documents concerning your complaint within ten (10) working days. You have the right to attend this meeting and you have the right to have someone attend this meeting with you to support and advocate for your concerns. You may also bring additional written information that you feel would be helpful.

You will receive within 10 working days a written response of the action plan to resolve your appeal.



FORMAL COMPLAINT FORM

TO BE COMPLETED BY CLIENT, OR CLIENT REPRESENTATIVE

Client name: _____ Date: _____ Phone #: _____

Name of person with complaint (if other than client): _____

Relationship to client: _____ Staff member(s) involved: _____

Have you shared your complaint with this staff person? Yes No

Please describe your complaint in detail. Provide dates and circumstances. Add pages if necessary.

Does the nature of your complaint involve harm or risk of harm to yourself or others? Yes No

If Yes, please explain _____

What do you think needs to happen to resolve your complaint? _____

Client's Signature (or Client Representative): _____

Oregon Health Plan Members Only: Do you want your complaint sent to the State OHP Office? Yes No

ADMINISTRATIVE PURPOSES

Received by _____

Sent to _____

Date _____

Date _____



**LifeWorks NW
RESPONSE TO COMPLAINT**

LEVEL ONE

TO BE COMPLETED BY LIFEWORKS NW SUPERVISOR

Client Name: _____ Date of Complaint: _____

Contacts made in relation to complaint: _____ Date: _____

_____ Date: _____

Action taken (*include dates and signatures*) _____

Resolved

Referred to Level Two (*appeal of hearing at Complaint & Grievance Committee*)

Reviewed By:

Name/Title: _____ Date: _____

cc: Client or Client Representative
Complaint Log
VP of Clinical Services

Attach this form to written complaint



LifeWorks NW
RESPONSE TO APPEAL OF COMPLAINT ACTION
LEVEL TWO

TO BE COMPLETED BY CHAIR OF COMPLAINT & GRIEVANCE COMMITTEE

Client Name: _____

Date of Meeting: _____ Date of Original Complaint: _____

Committee Members Present:

Name: _____	Program: _____
Name: _____	Program: _____
Name: _____	Program: _____
Name: _____	Program: _____

Others Present at Meeting:

Name: _____	Relationship to Client: _____
Name: _____	Relationship to Client: _____
Name: _____	Relationship to Client: _____

Summary of Appeal and Objections to Level One Complaint Action:

Summary of Level Two Action Plan:

Resolved

VP of Clinical Services: _____ Date: _____

cc: Client or Client Representative
Complaint Log

Attach this form to written complaint and to written appeal