



GRIEVANCE FORM Healthy Way LA

Note: If you cannot read or understand this form, call the Department of Mental Health Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

MEMBER INFORMATION

Member Name (Last)	(First)	Birth Date:	Mo.	Day	Yr.	HWLA Member ID #
Address (Street)		(City)	(State)			DMH IS #:
		(ZIP Code)				
Telephone (Home)	(Cell)					(Alternate)
Name of person completing this form, if different from member name					(Daytime Telephone)	

Where did the problem occur? (Name of Hospital, Provider's Office, Clinic or Pharmacy)	Date of Incident:	Mo.	Day	Yr.
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Please describe what happened as specifically as possible: Include the order in which things happened and how you were affected. **For additional space use page 2 of this form or add another piece of paper.**

What action or result are you asking for?

I understand that the Department of Mental Health Patients' Rights will contact me within sixty (60) days to give me a decision.

Signature of member/member's representative

Date:

Describe What Happened as Specifically as Possible:

PLEASE RETURN THIS FORM TO THE DEPARTMENT OF MENTAL HEALTH PATIENTS' RIGHTS BY DOING ONE OF THE FOLLOWING:

- Fax it to the Department of Mental Health Patients' Rights at (213) 365-2481
- Return the form in person to the Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020
- Mail it to the Department of Mental Health Patients' Rights, 550 S. Vermont Avenue, Los Angeles, CA 90020

INTERNAL USE ONLY

1. DMH Provider (Directly Operated, LE, PPP/FQHC):
2. HWLA Member ID#:
3. DMH IS#:
4. Grievance Code:
5. Grievance Received: In Person By Phone By Mail By Fax

Grievance Received By:

Time:

Date: