LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

Patient Complaints and Grievances (PCG)

Portal Application User Manual

Version 2024.2

May 22, 2024

Table of Contents

Purpose

The purpose of the Patients Complaints and Grievance solution is to allow consumers to report grievances, and appeals/expedited appeals online. The Department of Mental Health Patient's Rights Office staff will receive, track and triage the grievances and appeals/expedited appeals to ensure they are properly assigned and resolved in a timely manner.

Accessing the Portal

To access PCG Portal, copy and paste the below URL into your internet browser. The recommended browsers are Google Chrome and Microsoft Edge.

PCG Portal Link: https://lacdmhpcg.powerappsportals.us/en-US/

GRIEVANCE, APPEAL AND EXPEDITED APPEAL INFORMATION AND INSTRUCTIONS

Click 'Submit Grievance/Appeal' button at the bottom of the main page

How to fill an 'Grievance' or 'Appeal/Expedited Appeal'

Fill-in as much information as possible.

The fields with the red asterisk (*) are required fields:

I wish to file a(n)*:

Select from the following:

- Grievance
- Appeals
  - Check the box if you are requesting that your appeal be processed through the Expedited Appeals Process
  - Grievance ID* - refer to the letter received; Grievance ID starts with "COM"; exact match is required

Person Filing

Fill-in as much information as possible, so that any correspondence can be mailed and delivered accordingly

Relationship to Beneficiary/Consumer: Select from the following:

- Self
- Family
- Conservator
- Provider/Practitioner
- PRO Advocate

If the PRO Advocate option is selected, then "PRO Advocate Name" will be a required field

If you selected “Family”, “Conservator”, or “Provider/Practitioner”, then fill-in as much information as possible.

Enter the required information:

• First Name*	• MI	• Last Name*	
• Contact Phone Number	• Email Address		
• Address*	• City*	• State*	• Zip Code*

BENEFICIARY/CONSUMER INFORMATION

Note: If you selected “Self” in the above section, then most of the following fields will auto populate.

If you selected “Family”, “Conservator”, or “Provider/Practitioner”, then fill-in as much information as possible.

• First Name*	• MI	• Last Name*	
• Contact Phone Number	• Email Address	• Address*	
• Address*	• City*	• State*	• Zip Code*
• Birth Date*	• Medi-Cal #		

FILED AGAINST

Fill-in as much information as possible, so that the correct Facility/Provider/Program can be addressed.

• Name of Facility/Provider/Program*		• Phone #	
• Address	• City	• State	• Zip Code

DESCRIPTION OF GRIEVANCE: (Attach any supporting documents with the Grievance.)

If you selected to file a ‘Grievance’.

Fill-in as much detail as possible for a better understanding of why you are filing a ‘Grievance.’

-What is the complaint? *

-Did you talk to your provider about the complaint?

If you answered ‘Yes’

-What was their resolution?

-What resolution would you like?

DESCRIPTION OF APPEAL: (Attach any supporting documents with the Appeal.)

If you selected to file an 'Appeal/Expedited Appeal'.
Fill-in as much detail as possible for a better understanding of why you are filing an 'Appeal/Expedited Appeal'.

Explain why you disagree with the decision on your grievance*
What resolution would you like?

Attach a file

You can add an attachment to your Grievance or Appeal/Expedited Appeal.

Enter the code from the image in the box to be able to submit successfully.

Click 'Submit'

After successful submission, you will see an 'ACKNOWLEDGEMENT OF YOUR REQUEST'.

Take note of your case number for future reference. Print or save as you wish.

Done.