ALLEGAN COUNTY COMMUNITY MENTAL HEALTH

Date/Time: _____

Grievance Intake Form

Complainant's Name:	Registered Consumer? Yes / No (circle one)
NOTE: If complainant is not a registered consumer, record the relationship (i.e. guardian, parent of a minor child, friend/family member, provider staff, other:	
Street Address: City/State/Zip: Phone No.: Alt. Phone No.:	
Provide a brief description of your concerns (use additional pages if necessary)	

If filing a grievance on behalf of a client, please provide client's name:		
Client's D.O.B.:	Medicaid: Yes or No Client ID No.:	Circle Population: (MI, DD, SUD, C&F, Other) Service(s) Type:

Circle one (1) Grievance Category: NA if Not Apply: _____

Staff person's name/agency (if grievance involves a CMH or Agency employee):	• Attitude/Service • Billing/Financial Issues • Policy/Procedure • Quality of Care • Quality of Practitioner Office Site	• Request for Change in Services • Service Acceptability • Service Accessibility • Service Availability • Suggestions/Recommendations

Name of person completing the form:	Phone No.:	
Affiliate CMHSP: **Allegan County Community Mental Health**	County: **Allegan**	

The Customer Service Representative will attempt to have grievances resolved as soon as possible, and no later than 90 days, as required by the Michigan Department of Human and Health Services. If you have any questions or concerns, please feel free to contact ACCMHS Customer Services at (877) 608-3568 or (269) 686-5124, Fax (269) 673-2738, Email customerservices@accmhs.org

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