You Turn
Behavioral Health Services

GRIEVANCE / APPEAL / EXPEDITED APPEAL FORM

Type of Grievance: ☐Grievance ☐Appeal ☐Expedited Appeal

Today's Date: _____

Name of Client: _____ Birthdate: _____

Address: _____

Phone: _____ Email: Phone: _____

Do you have Medicaid? Yes No

PLEASE PRINT CLEARLY. BE SPECIFIC BY GIVING NAMES, DATES, AND TIMES WHENEVER POSSIBLE. (attach additional sheets if needed)

Please describe the issue. _____

_____

_____

_____

Explain how you have tried to resolve the issue. _____

_____

_____

_____

_____

What would you like to see happen: _____

_____

_____

_____

Individual Receiving Complaint

Name: _____

Address: _____

Phone Number: _____ E-Mail Address: _____

Signature of Individual Receiving Complaint

Date

FOR OFFICE USE ONLY

Results of Complaint Investigation

Signature & Position of Person Conducting Investigation

Date

Action(s) Taken to Resolve the Complaint