Mental Health Recovery Services (MHRS)
Quality Management Services (QMS)

Grievance Tracking Form

(Upon completion of form, send to AQIS for Medi-Cal Beneficiaries only)

Grievance Information (complete in full)

Medi-Cal Beneficiary Name: _____ Medi-Cal Status Verified: ☐ Yes ☐ No

Program Name: _____ ☐ County ☐ Contract

☐ Adult and Older Adult Mental Health & Recovery Services [AOAMHRS]

☐ Children and Youth Prevention Mental Health & Recovery Services [CYPMHRS]

☐ Patients' Rights Advocacy Services [PRAS]

☐ Drug Medi-Cal Organized Delivery Systems [DMC-ODS]

Service Chief/Program Director: _____

Service Chief/Program Director Phone: _____

Date of Reported Grievance: _____ Client Declined Grievance Process: ☐ Yes ☐ No

Grievance Resolved by End of Next Business Day: ☐ Yes ☐ No

Describe how the grievance was resolved:

Change of Provider Request: ☐ Yes ☐ No

Name of the provider that the client is requesting to change from: _____

Additional Information

Reporting Party Information

Clinical Staff Name: _____ Clinical Staff Phone: _____

Date Form Completed: _____ Time Form Completed: _____ AM/PM

Important Information

You must complete the Grievance or Appeal Form in addition to this form.	Please send both the Grievance or Appeal Form and Grievance Tracking Form via [secure] email to AQISgrievances@ochca.com or fax to (714) 834-0775	For questions, please contact QMS main line: 714-834-5601