



### GRIEVANCE AND APPEAL FORM

If you need assistance completing this form, you may contact your Community Mental Health Provider (CMHP) and request help from a staff member other than the person you are filing a grievance about. If you do not want to file a grievance directly to the Mental Health Provider, you may direct it to Greater Oregon Behavioral Health, Inc. (GOBHI) by writing to 400 East Scenic Drive, Suite 2343, The Dalles, OR 97058 or calling 1-800-493-0040, TDD 1(800) 399-7335.

Date \_\_\_\_\_ CMHP \_\_\_\_\_

Name \_\_\_\_\_ OHP# \_\_\_\_\_

Date of incident or denial \_\_\_\_\_

If denial of service, do you want your benefits to continue?    \_\_\_ Yes    \_\_\_ NO

Does this grievance involve an urgent situation that cannot wait?    \_\_\_ Yes    \_\_\_ No

If yes, state the reason \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Grievance: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attach additional sheets if necessary.

What would you like to have happen in this matter? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

-----OFFICE USE ONLY-----

Good Cause Exception:    \_\_\_ Yes    \_\_\_ No    Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_