

Grievance Notice

If you have a concern or complaint, please bring it to the attention of your counselor or another staff member with whom you feel comfortable. Our staff will help you address your concerns. If Medicaid/OHP pays for your services, you can also contact your CCO directly.

After speaking with our staff, if you or the person acting on your behalf feels the matter is still unresolved, please write your concern on a grievance form and submit it to the Executive Director (admin@transponderoregon.org). Please include all the information that will help our staff understand your concern and your suggestion for resolution. Within 30 days, our staff will communicate with you and/or your representative in writing regarding the decision on the grievance and information explaining the appeal process.

If you would like assistance putting your grievance in writing, please ask a staff member for assistance.

If you would like a grievance form, please ask for one.

If you would like more information on the grievance process, requesting an expedited grievance, appeals, immunity, or retaliation, please request a copy of the grievance and appeals policy and procedure.

Telephone numbers:

TransPonder: 541-321-0872

Oregon Health Authority, Health Systems Division: 503-945-5763 http://www.oregon.gov/OHA/healthplan/pages/complaints-appeals.aspx

Disability Rights Oregon: 503-243-2081

Governor's Advocacy Office: 503-945-6904

HealthShare Oregon: 503-416-8090 http://www.healthshareoregon.org/for-members/appeal-and-grievances.html



Formal Grievance Form

This form is to be used to file a formal grievance. All four sections must be completed and will serve as the source document for the grievance process (attach additional pages if more room is necessary). Please answer all questions fully. All supporting documentation must be attached to this grievance form at the time the grievance is filed. Additional information may be requested as necessary. In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures are completed, the individual or guardian of the individual may request an expedited review.

INFORMATION					
Name:			Today's Dat	te:	
Status:	Participant 📃	Staff 📃	Other 📃	If other, please describe:	
Basis of complaint:	Harassment	Discrimination	Unfair Action / Violation of Rights		
Grievance is filed under:		Harassment and Non-Discrimination Policy		Staff / Admin General Grievance Policy	
Preferred metho	d of contact:				

1. What was the date of occurrence and what specific behavior, condition, or violation of policy or procedure occurred which you consider discriminatory, harassing or unfair / violated your rights?

2. How have you been adversely affected by this situation?

3. What specific action have you taken to follow the guidelines for informal resolution as outlined in the Employee Handbook *or* the practice policies? What has been the outcome of these efforts?

4. What specific remedy do you request?

TransPonder: 541-321-0872 Disability Rights Oregon: 503-243-2081 Trillium Community Health Plan: 877-600-5472 PacificSource: 888-977-9299 The Governor's Advocacy Office: 503-945-6904

Name:	Signature:	Date:	
If under 18 years o	ld) Parent/Guardian Signature:	Date:	
	♣ STAFF USE ONLY ♣		
Staff Name:	D	Date Received:	
Resolution/steps tak	ken:		

Staff Who Resolved:

Date of Resolution: