Marion County Health Department

Instructions for filing a Complaint

As a consumer of Marion County Health Department (MCHD), if you are having a concern or problem with the services or treatment you are receiving from us, we encourage you to attempt to discuss the issue with the staff person at the facility you are receiving services from.

If you remain dissatisfied after that discussion, you may file a Complaint to us, either verbally or in writing. Your Complaint will be kept confidential and you will not be treated disrespectfully for filing a Complaint.

Filing the Complaint:

1. Complete the Complaint Forms. These forms are available at any MCHD facility, on our web site at http://health.co.marion.or.us/, or by calling us at 503-584-4824. If you need help completing the Complaint form, you may ask any MCHD staff member to assist you. You may also have someone else file the Complaint for you. We may ask you to sign a release in order to allow us to communicate with this individual.

2. Turn the Complaint forms into the facility you are receiving services from or mail it to us at:

   MCHD
   Quality Improvement Coordinator
   3180 Center Street, Room 2100
   Salem, Oregon 97301

   If you are an OHP member, receiving Mental Health services through Mid Valley Behavioral Care Network (MVBCN) you may also mail this to them, if you prefer, at:

   MVBCN
   Consumer Affairs Specialist
   1660 Oak Street, Suite 230
   Salem, Oregon 97301

   Call if you need help completing the form: 503-361-2647

What to Expect Next:

We will review the details of the Complaint. If we need more information from you, we will contact you. We will attempt to mail a written decision to you within 5 working days. If we need more time than this, we will notify you and tell you why and how much more time is needed. The longest amount of time before you receive a written response will be 30 calendar days.

If you are not satisfied with our written decision, you may contact the State of Oregon Medicaid Policy Analyst at 503-947-5528.

Note: If the problem is about a Notice of Action you received, you do not want to file a Complaint. Instead, you will want to file an Appeal or request a Hearing. Information about how to do this should be included in your Notice of Action.

Date Complaint Received: ____________

Marion County Health Department

Complaint Form (for Non BCN Services)

Client's Name: [ ] Client's Phone #: [ ]

Client's Address: [ ]

If you are completing this for the client, please fill in the following:

Your Name: [ ] Your Phone #: [ ]

Your Address: [ ]

Do you believe this Complaint is *URGENT* and should be expedited because your life, health and/or ability to function is in serious jeopardy?

Yes: [ ] No: [ ] If yes, why do you believe it is *Urgent*?

____

What happened? (attach additional page/documentation if needed)

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____

When did this happen (date/time)? ______________________

Where did this happen (agency/location)? ______________________

Who else was involved (name/phone#)? ______________________

What would you like to be done about this?

____

Is this Complaint the result of your services being denied, suspended, reduced or terminated?

Yes ☐ No ☐

If yes, do you want us to continue services for you until you get a final decision about your Complaint? (Note: if yes, you may be required to pay for the cost of services if you lose the final decision).

Yes ☐ No ☐

I allow MCHD to investigate and share information for the purpose of investigating/resolving this Complaint. If someone else is filing this on my behalf, I also give permission for MCHD to exchange information with the individual named above:

Client's Signature: [ ] **Complainant's Signature (if not the Client):** [ ]