

PRSN GRIEVANCE FORM

This form is to be completed when filing a Grievance request with the Peninsula Regional Support Network (PRSN). This form will help the PRSN understand the resolution you desire.

Name of individual filing Grievance: _____

Address: _____

Phone Number: _____

Name of enrollee advocate/representative: _____

Address: _____

Phone Number: _____

I had/ have Medicaid coverage during the time the Grievance action(s) occurred? Yes No

PRSN Agency/Subcontractor that Grievance involves: _____

Key individuals involved in the Grievance: _____

Grievance facts and circumstances summary: _____

Has the Complaint been filed with the mental health agency/entity? Yes No

What was the agency Complaint response: _____

Page 2

Description or portions of Federal regulations, contract, or Washington Administrative Code which consumer or consumer advocate/representative believes were violated: _____

Enrollee defined solution: _____

Additional comments: _____

Medicaid recipients, only: Your mental health Medicaid benefits shall continue while the Grievance Resolution is pending. If the final resolution is adverse to you by upholding the original decision, you may be financially responsible for the cost of the services furnished while the Grievance is/ was pending. Please contact the number below, if you believe your benefits have discontinued.

I hereby affirm that the information contained in this Grievance document is true to the best of my information and belief.

SIGNED: _____

DATED: _____

CONTACT: Stacey A.S. Smith, Resource Manager
Peninsula Regional Support Network
614 Division Street, MS-23
Port Orchard, WA 98366-4676

Phone: (360) 337-4648 or (800) 525-5637
FAX: (360) 337-5721

(Rev. 5/2007)