



Grievance Form

The purpose of the grievance process is to offer clients, authorized representative(s) of clients, and providers a forum to register complaints or concerns pertaining to the quality of care delivered to clients. Appropriate reasons for filing a grievance may include: excessive waiting periods, inappropriate treatment or services, poor quality of care, unnecessary delays in providing care, or improper delivery of service or treatment. AAIR actively seeks input on the quality of the program and its providers, and encourages those wishing to file a grievance to do so. If all the required information is present, AAIR will notify you of its decision in writing.

Section A - Client or Provider Information

1. Name of client or provider	2. Date
3. If applicable, name of authorized representative	4. Email Address
5. Telephone Number	6. Telephone Number (Alternate)
7. Mailing Address (Street/P.O. Box, City, State, ZIP Code)	

Section B - Grievance Statement

1. Name of party against whom the grievance is being filed: _____

2. Describe any complaints or concerns you have pertaining to the quality of care provided. Attach additional pages if necessary.

Section C - Desired Outcome

Describe what change you desire to take place to resolve the issue. _____

Section D - Other Information

Provide any additional information that could be helpful to AAIR in resolving the issue.

Section E - Certification

I certify that the information provided in this grievance is true and correct.

Signature

Date



Instructions

Section A - Client or Provider Information

1. Name of applicant, client, or provider - Provide the first and last name of the applicant, client, or provider who is filing the grievance.
2. Date – Provide the date on which the grievance form is filed.
3. Name of the Authorized Representative – If applicable, provide the first and last name of the authorized representative.
4. Email Address – If you can be reached by email, provide your email address.
5. Telephone Number - Provide the area code and telephone number where the client, authorized representative, or provider can be reached.
6. Telephone Number (Alternate) – Provide an alternate area code and telephone number where the client, authorized representative, or provider can be reached.
7. Mailing Address – Provide the street or post office box, city, state, and zip code where mail is received by the client, authorized representative, or provider.

Section B - Grievance Statement

1. Provide the name of the party against whom the grievance is being filed.
2. Provide a description of any complaints or concerns you have regarding the quality of care provided.

Section C – Desired Outcome

1. Provide a description of what change you desire to take place to resolve the issue.

Section D – Other Information

1. Provide any additional information that could be helpful to AAIR in resolving the issue.

Section E – Certification

Certify that the information provided in this grievance is true and correct.

Please mail or fax this report to:

AAIR Compliance Officer
CALIFORNIA RURAL INDIAN HEALTH BOARD
4400 Auburn Boulevard, 2nd Floor
Sacramento, CA 95814
Fax: (916) 929-7246