

WASATCH MENTAL HEALTH SERVICES  
SPECIAL SERVICE DISTRICT

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## **Medicaid Enrollee Grievances – C – 3.08**

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### **Purpose:**

Wasatch Mental Health (WMH) is committed to providing quality services for Medicaid Enrollees, family members and providers. The purpose of this policy is to provide a timely means to address client grievances and to provide an opportunity for improving WMH services. WMH must provide a decision with regard to a grievance within 45 calendar days, and in certain circumstances may extend the decision for an additional 14 calendar days. **Failure to act within the required timeframe constitutes an Action.**

### **Definitions:**

#### **Action Regarding Grievances**

Failure to act within the required time frames for solution and notification of appeals and grievances. (i.e., WMH did not settle a grievance in the required time frame (45 calendar days).

#### **Enrollee:**

Any Medicaid eligible person whose eligibility has been established by Utah Department of Health and who resides within the geographic boundaries of Utah County, excluding residents of the Utah State Hospital and Utah State Developmental Center.

#### **Grievance:**

A grievance is defined as a complaint or any expression (written or oral) of dissatisfaction about any matter related to the administration, conduct, or performance of the Center or its staff relative to the delivery and provision of mental health services. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness by WMH or an employee, failure to respect the Enrollee's rights.

#### **Receipt:**

An oral or written acknowledgment of the following:

- WMH will notify the client and affected parties, orally or in writing, of the decision within 45 calendar days of receipt of the grievance.
- WMH may extend the time frame for making a decision on the grievance by up to 14 additional calendar days.
- If needed, WMH will provide toll-free numbers that have adequate TTY/TTD and interpreter capability.

The receipt, of the above acknowledgement information, is printed on the back of the grievance form. The staff member must document the date of the receipt on the grievance form.

**Policy:**

- A. Care Management Services (CMS) and its Enrollee Customer Service Representative (CSR) will exercise oversight responsibility for ensuring all policy, procedure, and processes associated with WMH's Grievance System are adhered to including tracking, report preparation and writing, timeliness compliance, and records documentation. WMH shall maintain complete records of all grievances, including decision for a period of six years.
- B. WMH shall inform Enrollees orally and/or in writing of their right to file a grievance and of their right to appeal when WMH fails to act within the time frames established for resolution and notification of Grievances.
- C. The information provided to the Enrollee will be stated in simple, clear, language and include information needed for the Enrollee and/or the provider to file a grievance. WMH will provide reasonable assistance as needed.
- D. WMH shall not retaliate, inhibit, or take any discriminatory action against an Enrollee or Enrollee's provider who files a grievance. Grievances shall be received in confidence and discussed only with persons involved in the decision process.
- E. WMH shall provide oral interpreter and oral translation services, sign language assistance and access to the grievance system through a toll-free number with TTY/TDD and interpreter capability.
- F. WMH shall make grievance informational and instructional materials available in the prevalent non-English language. Information and instruction materials will also be made available to Enrollees who are visually limited or have limited reading proficiency.
- G. WMH shall submit written summaries of all grievances, with the exception of fee for service Medicaid Enrollees, to the Utah State Department of Health, using department templates as required by the Medicaid contract. In addition, WMH's Customer Service Representative will log, monitor and track all Enrollee/affected parties grievances and decisions in the Grievance Spreadsheet (See attachments B). As per Medicaid Contract requirements, all fields in the spreadsheet must be completed.
- H. WMH's CSR shall monitor and report to the Quality Improvement Committee all grievances and decisions for quality improvement purposes including, the determination of trends, and any systemic issues that need to be addressed.

## Grievance Procedures:

1. See attachment A for flowchart process.
2. Enrollees, at the time of their admission, will be given a Medicaid Member Handbook and informed of their rights including the right to file a grievance.
3. WMH will provide a Suggestions/Complaint box in reception areas where Enrollees may leave their grievances. WMH's Customer Service Representative (CSR) shall check and maintain the complaint boxes and initiate a grievance resolution process in behalf of the Enrollee. Enrollees may also express a grievance directly to any employee.
4. A provider, acting on behalf of an Enrollee as an authorized representative, may file a grievance orally or in writing at any time.
5. Program managers or administrators who immediately handle grievances that are not the result of an Action will complete a **7.59 WMH Enrollee Grievance form** or send an e-mail to the CMS including the following information:
  - a) date the grievance was received;
  - b) name of the staff member taking the grievance;
  - c) date and method of receipt (acknowledge) either orally in writing. **(Use form 7.59i-N8 Notice of Receipt of Grievance)**.
  - d) a summary of the nature of the grievance, including the name of the Provider or other staff or individual involved/named in the Grievance, if it involves a person;
  - e) date and summary of the resolution of the grievance;
  - f) name, title and credentials of the individual(s) resolving the grievance;
  - g) date the client was notified of the resolution of the grievance and how the client was notified;
  - h) Indicate if there is any other pertinent documentation needed to maintain a complete record of the grievances. Information must be forwarded to the CSR.
6. When a grievance cannot be handled immediately, the assisting staff member shall:
  1. Give the Enrollee assistance in completing the required form for submitting a written grievance. **(Use form 7.59 WMH Enrollee Grievance Form)**. If the client gives an oral grievance, the staff member may complete the grievance form or send an e-mail to the CSR including the information in 5 above, a-h).
  2. Provide, if needed, reasonable assistance in taking procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
  3. Acknowledge receipt of the grievance orally or written **(Use form 7.59i-N8 Notice of Receipt of Grievance)** and appropriately notify all affected parties of the disposition of the grievance.
  4. Submit written grievances to the CSR. If the receipt was written, attach a copy to the form.
7. The CSR shall enter oral and written grievance in the grievance spreadsheet and forward a copy of the grievance (form or email) to the appropriate program manager or administrator for review and decision.

8. The program manager or administrator shall ensure that the staff who make the decision on the grievance are individuals who:
  1. Were not involved in any previous level of review or decision-making, if applicable to the nature of the grievance and;
  2. Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by Medicaid, in treating the Enrollee's condition or disease:
    - a) A grievance regarding denial of a request for an expedited resolution of an Appeal; or
    - b) A grievance that involves clinical issues.
9. When the program manager or administrator is able to make a *decision within the 45-calendar day* Medicaid required time frame, the program manager or administrator will provide a response to the Enrollee and affected parties regarding the grievance and report the decision back to the CSR. The program manager's decision, does not by necessity, need to be in the Enrollee's favor. The decision may be given to the parties either orally or in writing. If the manager is not able to talk with the client verbally, the manager will send a decision letter to the client's last known address.
10. The program manager or administrator, when necessary, will make any changes needed in the department's operations, address any deficits in employee/Enrollee relations, and train staff in the new procedures. Any organizational policy or operations that need to be changed will be reported to the program manager's division director.
11. The CSR will log information, as per PMHP Medicaid Contract requirements, in the grievance spreadsheet (**See attachments B for example**). If the grievance and decision is in writing, the CSR will maintain a copy of the grievance and any other pertinent documentation needed to maintain a complete record of all written and oral grievances.

**Extensions for Grievance:**

1. The program manager or administrator may extend the time frame for making a decision on the grievance by up to 14 additional calendar days if:
  - a) The Enrollee requests an extension; or
  - b) WMH justifies (to Medicaid upon request) a need for additional information and how the extension is in the Enrollee's interest.
2. When an Enrollee requests a grievance extension, the CSR will acknowledge receipt orally or in writing. When the program manager or administrator extends the time frame, and the Enrollee did not request the extension, the program manager will give the Enrollee, and all affected parties, written notice of the reason for the delay (**use form 7.59j-N9 Notice of Grievance Extension**).
3. The CSR will log the information, as per PMHP Medicaid Contract requirements, in the grievance spreadsheet. The CSR will maintain documentation of any extension request.

## **Action Procedures:**

### **Failure to Resolve Grievance within Required Time Frame Constitutes an Action**

1. When a program manager or administrator does not notify the Enrollee of the grievance decision within the 45-day Medicaid required time frame and the additional 14 calendar day extension was not filed, the program manager or administrator shall notify the CSR.
2. The CSR will send the Enrollee, and all affected parties, a written Notice of Action letter explaining the reason why WMH did not make a decision about the grievance within the required time frame, the Enrollee's right to appeal, and explain that they may receive reasonable assistance with the appeal process from staff **(use form 7.59b-N2a Notice of Action and Appeal Rights)**.
3. The notice of Action shall clearly indicate the action that has been taken and provide a clear statement of the basis for the action. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format *(See policy C-3.10 Readability of Documents for testing procedures)*.
4. Should the Enrollee or other affected parties decide to appeal the action, the program manager or administrator will be excluded from the review of the appeal. The program manager or administrator must continue to try to resolve the grievance. ***(See procedures in the Action, Appeal and State Fair Hearing policy C-3.08B)***.
5. The CSR will log information, as per PMHP Medicaid Contract requirements, in the grievance spreadsheet. The CSR will maintain a copy of the Notice of Action, appeal request, extension, and any other pertinent documentation needed to maintain a complete record.

### **Grievance Filed with PHMP (Medicaid):**

When the Enrollee, or provider on behalf of an Enrollee, files a grievance with Medicaid, Medicaid will apprise the Enrollee or provider, of his/her right to file the grievance with WMH and instruction on how to do so. If the Enrollee/provider prefers, Medicaid will promptly notify the CMS Director or the CSR. Grievances submitted by Medicaid are considered an oral grievance. The CSR will follow the procedures and time frames outlined for grievances.

### **Right to Change and/or Terminate Policy:**

Reasonable efforts will be made to keep employees informed of any changes in the policy; however, WMH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

# Attachment A: Grievance Process

## Flowchart 6

### **Grievance Process**

#### **and Action 5, Failure to Resolve Grievance within Required Time Frame**

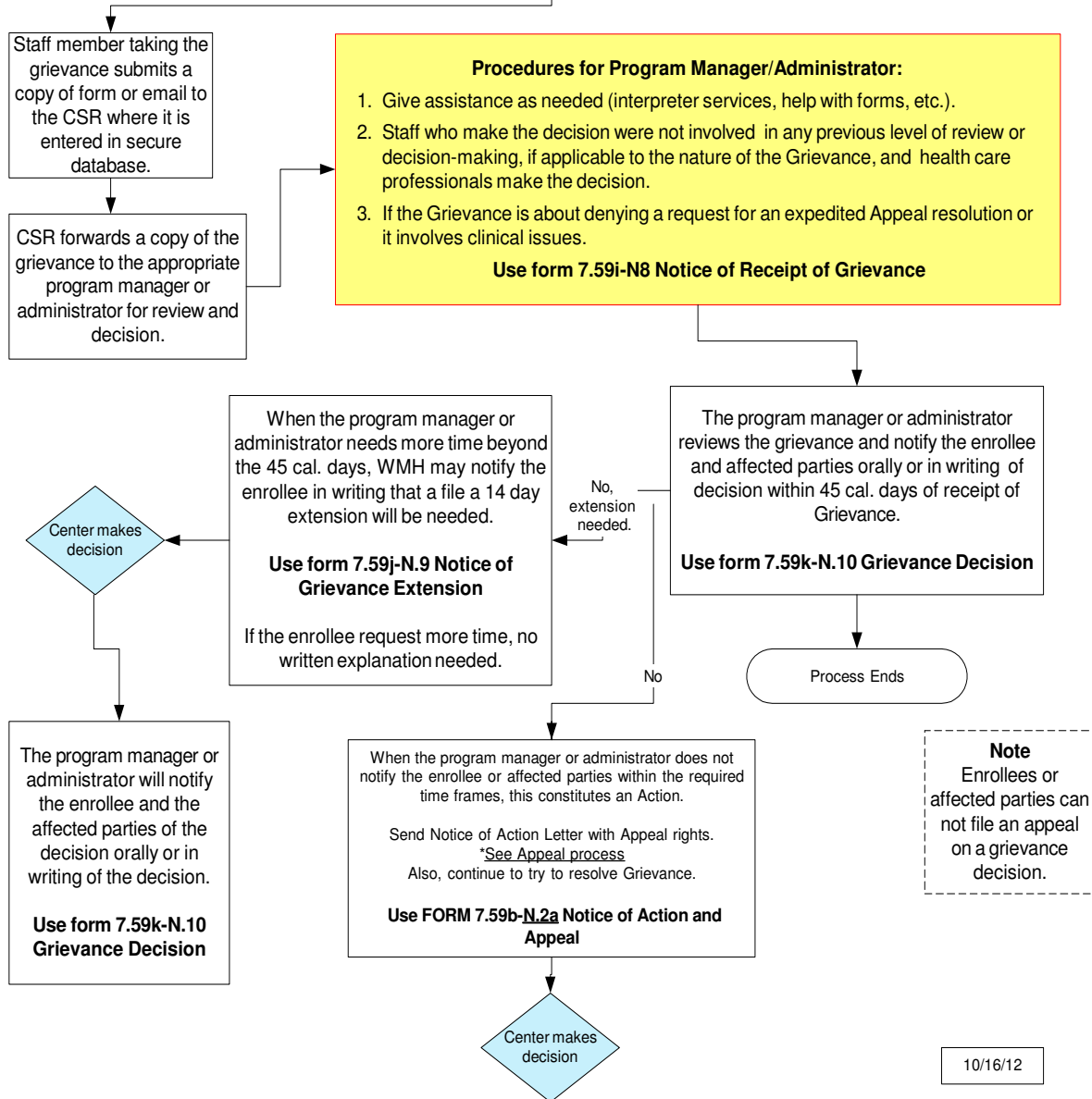
Enrollee/outside provider on Enrollee's behalf files Grievance orally or in writing. (Use form C-7.59).

If the the grievance is filed orally, the staff member may complete a grievance form or document the grievance in an email to the Care Management Assistant/ Customer Service Representative (CSR). The email must indicate if a verbal or written receipt was given.

**Receipt information**

- (1) WMH will notify the Enrollee and affected parties, orally or in writing, the decision within 45 calendar days of receipt of the grievance.
- (2) WMH may extend the time frame for making a decision on the grievance by up to 14 additional calendar days.
- (3) Provide toll-free numbers that have adequate TTY/TTD and interpreter capability.

Written receipt use form **7.59i-N8 Notice of Receipt of Grievance**.



## Attachment B: Grievance Log

Wasatch Mental Health Grievance System Log			
Date Grievance Received:		Staff documenting Grievance:	
Client Name:		Feedback Type:	
Client ID#:		Category:	
Division:		Retrieval Mode:	
Dept where the grievance took place:		Call Client:	
Staff name/Credentials:		Acknowledgment-Receipt Type:	
Insurance Type:		Receipt Date:	
		Access Related:	
		Quality Related:	
		Other:	
		Resolution Statuses:	
		Timeline (45 Days):	2/14/00
		# of days between receipt and resolution:	0
		14 Day Extension Needed?	
		Requested by:	
<b>Summary of Grievance</b>			
<b>Summary of Resolution</b>			
Date Resolved:		Staff resolving grievance (include Title/Position/Credentials):	
Date Client Notified:		Other pertinent info in file:	
Method of Notification:			
Other Individuals Notified:			
Grievance resolved within in the required time frame?		Medicaid Reporting Period:	

## Attachment B: Action Log

### Wasatch Mental Health Action Log

Reporting Period:

Client Name	Client #	Affected Parties	Provider Name	Action Process	Date of Action Letter	Extension Needed Y/N?	Extension request by	Other pertinent action information in file Y/N?

- Action Type Key**
- 1 - Denial or limited authorization of a requested service, including the type or level of service.
  - 2 - Reduction, suspension, or termination of a previously authorized service.
  - 3 - Denial in whole or in part of payment for services.
  - 4 - Failure to provide first face-to-face services in a timely manner, due to Center limitations, and resulting in client dissatisfaction.
  - 5 - Failure to act within the required time frames for solution and notification of appeals and grievances.

Total:



## Grievances Spreadsheet Definitions

WMH's Care Management Assistant (CMS) will log all Enrollee/affected parties Grievances, Actions, and Appeals in the Grievance, Action, and Appeal spreadsheet. As per PMHP Medicaid Contract requirements, all fields in the spreadsheet must be completed.

<b>Date Grievance Received:</b> Enter the date the oral/written grievance was received and documented.	<b>Access/Quality/Other Related:</b> Select the type of code from the drop down menu - Access Related, Quality Related, Other: (See attachment "Type of Grievance Codes and Grievance Resolution Codes:)
<b>Client Name:</b> Enter Enrollee's name.	<b>Resolution Status:</b> Select the type of code from the drop down menu (See attachment "Type of Grievance Codes and Grievance Resolution Codes:)
<b>Client ID#:</b> Enter Enrollee WMH ID number.	<b>Timeline (45) days:</b> A date will automatically be entered. This will help determine when the 45 day deadline will be.
<b>Division:</b> From the field's drop down menu, select the program the Enrollee receives services from (Youth or Adult).	<b># of days between receipt and resolution:</b> automatically calculate the number of days it took to resolve the grievance.
<b>Dept where the grievance took place:</b> From the field's drop down menu, select the program where the grievance occurred.	<b>14 Day Extension Needed?</b> Yes or No if an extension was requested.
<b>Staff name/Credentials:</b> If the grievance involves a staff member, enter staff members name.	<b>Requested by:</b> Name of individual requesting the extension.
<b>Insurance Type:</b> Enter Enrollees insurance provider. This will determine if it will need to be reported to Medicaid.	<b>Summary of Grievance:</b> Enter a summary of what the grievance is about. Include dates and individuals involved.
<b>Staff Documenting Grievance:</b> Enter the name of the staff member who accepted the grievance.	<b>Summary of Resolution:</b> Enter a summary of the decision/resolution. Include dates and individuals involved.
<b>Feedback Type:</b> From the field's drop down menu, select how the grievance was received (Verbal or Written)	<b>Date Resolved:</b> Date the Enrollee was notified of the grievance decision/resolution.
<b>Category:</b> From the field's drop down menu, select (medical, therapy, personnel, center procedures, facility)	<b>Date Client Notified:</b> Enter the date the Enrollee/other-affected parties were notified of the decision.
<b>Retrieval Mode:</b> From the field's drop down menu, select how the grievance was received (in-person, telephone, mail, suggestion box.)	<b>Method of Notification:</b> From the field's drop down menu, select how the Enrollee/other-affected parties were notified of the decision.
<b>Call client:</b> From the field's drop down menu, select Yes or No if the client requested a call back.	<b>Other individuals Notified:</b> Enter the name of the other-affected parties.
<b>Acknowledgement (Receipt) Type:</b> From the field's drop down menu, select how the Enrollee was informed that WMH will give the Enrollee a decision within 45 calendar days from the date their grievance was filed. If more time is needed, WMH will let them know (see sample of a written acknowledgment form # C-7.59i-N8).	<b>Staff resolving grievance:</b> Name of the individual(s) resolving the grievance include the individual(s) title and credentials. Ensure that individuals were not involved in any pervious level of review or decision-making and are health care professionals who have the appropriate clinical expertise.
<b>Receipt Date:</b> Enter the date the Enrollee was given the Acknowledgment.	<b>Other Pertinent Info in file:</b> Yes or No. Any other pertinent documentation needed to maintain a complete record and to demonstrate that they were adjudicated according to the PMHP contract provisions. The CMS will keep a complete hard copy record.
<b>Grievance resolved within the required time frame?</b> Yes or No. resolved within 45 days (14 additional days) from when the grievance was filed.	<b>Medicaid Reporting Period:</b> Enter annual reporting period.

## Type of Grievance Codes and Grievance Resolution

Code	Access/Capacity Related	Code	Quality Related	Code	Other
	Timely access to prescriber services (psychiatrist, PA or APRN)	Q-1	Disagree with treatment plan goals	O-1	Coordination with Health Plan, primary care physician or other provider, or with other agencies
A-2	Timely access to other treatment services, <u>other than not meeting performance standards for first face-to-face service</u>	Q-2	Clinical knowledge or expertise	O-2	A grievance regarding Center's denial of expedited resolution of an appeal
A-3	Emergency Services, <u>other than not meeting performance standards for emergency services</u>	Q-3	Clinician attitude (i.e., rude, impersonal)	O-3	Civil rights/other discrimination (e.g., race, color, religion, sex, age, disability, etc.)
A-4	Time of service	Q-4	Other staff attitude	O-4	Violation of Center's patient rights
A-5	Location of service	Q-5	Communication problems	O-5	Cultural /Ethnic Health Insensitivity
A-6	Waiting time for appointments too long	Q-6	Unethical behavior (including clinician discrimination)	O-6	Facility-related
A-7	Frequency of scheduled service	Q-7	Treatment impasse	O-7	Other
A-8	Access to requested therapist	Q-8	Other quality related—other than quality issues that constitute an action		
A-9	Requested therapist change denied	<b>** Grievance Resolution Codes</b>			
A-10	Provider turnover	<b>R-1</b>	<b>Grievance resolved within required time frame (i.e. 45 days + 14 calendar day extension)</b>		
A-11	Denial of a requested second opinion	<b>R-2</b>	<b>Resolution in progress - still within 59 days</b>		
A-12	Health Plan failed to make service authorization decision within 14 calendar days	<b>R-3</b>	<b>Resolution in progress, 59-day time frame has expired*</b>		
A-13	Other access related—other than access issues that constitute an ACTION	<b>R-4</b>	<b>Grievance resolved after 59-day time frame expired*</b>		
		<b>R-5</b>	<b>Not resolved due to client moving, phone disconnected, unable to locate, etc.</b>		
		<b>R-6</b>	<b>Not resolved –Client discontinued treatment</b>		
		<b>R-7</b>	<b>Not resolved– Client withdrew grievance</b>		





## Form # 7.59b-N2a Notice of Action

If you need this letter in Spanish, call the Wasatch Mental Health customer service representative at (801) 373-4760.

Si usted necesita esta carta en español, llame a un representante de Wasatch Mental Health al (801) 373-4760.

### Delete all information in Red before sending letter to client...

(The notice of action shall clearly indicate the action that has been taken and provide a clear statement of the basis for the action. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format. See policy C-3.10 Readability of Documents for testing procedures)

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" Wasatch Mental Health took the following action;

- We did not make a decision about your Grievance within the required amount of time (45 days.)

(Explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

If you are unhappy with this action, you have the right to appeal. The rest of this letter explains how to file an Appeal.

You must file your Appeal within 30 calendar days from the date on this letter.

You, your legally authorized representative or your provider may file your appeal. If you need help filing your appeal, call the Wasatch Mental Health customer services representative at (801) 373-4760. If you need an interpreter to help you file your appeal, call the Wasatch Mental Health customer services representative at (801) 373-4760.  
Outside of Utah County call 866-366-7987.

### To file an Appeal:

1. You may file your appeal by calling us at (801) 373-4760 and asking for the Wasatch Mental Health customer service representative.
2. If you call us to file your appeal, you must also send us a written appeal. Please use the enclosed written appeal request form. You must send us this form within **5 working days** of your call. If you do not send the follow-up written request within 5 working days of your call, you lose the right to appeal.
3. If you do not want to call first, you must send us your written appeal within 30 days of the date on the notice. Send us your appeal using the enclosed written appeal form.

4. If your provider files your Appeal, the Appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the action.
5. Send the complete written appeal to:

Wasatch Mental Health  
c/o Care Management Department  
750 North 200 West, Suite 300  
Provo, UT 84601

If you call us first to file your Appeal, we plan to make a decision within **15 calendar days** from the date you call. If you send us your Appeal in writing, **we plan to make a decision within 15 calendar days from the date we get your written appeal request.**

Sometimes we'll need more time to make a decision, or you may ask us to take more time. If so, we may take an additional 14 calendar days to make our decision. If we need to take extra time, we will send you a letter telling you that.

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### EXPEDITED (QUICK) APPEALS

If you or your provider believes taking this amount of time could place your life or health in danger, or that you might have a permanent setback, you may ask for an expedited (quick) Appeal.

#### **To file an expedited appeal:**

1. You may ask for an expedited appeal by calling the Wasatch Mental Health customer services representative at (801) 373-4760. You do not also have to send your Appeal in writing.
2. If you do not want to call first, check the "expedited Appeal" box on the enclosed Appeal form and send it to us.
3. If your provider files your appeal, the appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the action.

If we agree the decision needs to be made quickly, we will make a decision in **3 working days**. If you or we need more time to make the decision, we can take up to another **14 calendar days**. If we need more time, we will send you a letter telling you why.

Again if you have any questions please contact the Wasatch Mental Health customer services representative at (801) 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**  
**Affected Parties (if applicable)**

Enclosure: Appeal Request Form

**Wasatch Mental Health  
APPEAL REQUEST FORM**

1. Is the client or a provider requesting this *\*Appeal\**? Client? Or Provider? (Circle)
  
2. Name of Client: \_\_\_\_\_  
Client's Address: \_\_\_\_\_
  
3. Name of Provider Involved: \_\_\_\_\_  
Provider's Address: \_\_\_\_\_
  
4. The reason you are requesting the Appeal: \_\_\_\_\_  
\_\_\_\_\_
  
5. You may ask for an expedited (quick) decision on your Appeal if you believe taking the regular amount of time could place your life or health in danger, or that you might have a permanent setback.  
  
\_\_\_ Check here if you want an expedited Appeal.
  
6. If the Appeal is about decreasing or ending services, do you want these services continued during the Appeal process? Please remember if the Appeal decision is not in your favor, you may have to pay for these services.  
  
\_\_\_ Check here if you want these services continued.
  
7. If you need help filling out this form, an interpreter, or have any questions about the Appeal process please call (name or title) at (phone number).
  
8. **REMINDER!!** If you are **not** asking for an expedited (quick) Appeal, and you call us first to file your Appeal, you must send this form to us within 5 working days of your call, or you lose the right to Appeal.

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**Provider Permission Statement**

If your provider is filing the Appeal for you, you must give your written permission.

I \_\_\_\_\_ (your name) give my permission for  
\_\_\_\_\_ (provider's name) to file this Appeal for me.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

## Form # 7.59i-N8 Notice of Receipt of Grievance

If you need this letter in Spanish, call the Wasatch Mental Health customer service representative at (801) 373-4760.  
Si usted necesita esta carta en español, llame a un representante de Wasatch Mental Health al (801) 373-4760.

**Delete all information in Red before sending letter to client... (Centers – You are not required to give a written receipt of either an oral or written grievance. You may just give oral acknowledgement. This is a sample of a written acknowledgement. The same information needs to be given to Enrollees if you give oral acknowledgement)**

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]"

On "[Click here and type date]" we received your Grievance regarding **(explain details)**. We will give you our decision within 45 calendar days. Sometimes, we'll need more time to make a decision, or you may ask us to take more time. If we need to take extra time, we will send you a letter telling you that.

**If a provider filed the Grievance on Enrollee's behalf, adjust letter accordingly.**

If you have questions, call the Center's customer services representative at (801) 373-4760.

Sincerely,

Cc: **Private provider (if applicable)**  
**Affected Parties (if applicable)**



## Form # 7.59j-N9 Notice of Grievance Extension

If you need this letter in Spanish, call the Wasatch Mental Health customer service representative at (801) 373-4760.  
Si usted necesita esta carta en español, llame a un representante de Wasatch Mental Health al (801) 373-4760.

**Delete all information in Red before sending letter to client... (Centers – This form is only required for written grievances. You may use it for decisions on oral grievances if you want.)**

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" , we received a grievance from you.

We have not been able to make a decision on your Grievance yet. This letter is to let you know we need to take more time.

We need more time because (Explain reason for the delay, including type of information needed and from whom, if applicable).

We will give you our decision within 14 calendar days.

(Could individualize this further and explain how you'll give them decision – in writing if they gave you the Grievance in writing, or if oral Grievance, whether you'll call them/talk to them/give in writing.)

Sincerely,

[Click **here** and type your name]

Cc: Private provider (if applicable)  
Affected Parties (if applicable)

## Form # 7.59k-N10 Grievance Decision

If you need this letter in Spanish, call the Wasatch Mental Health customer service representative at (801) 373-4760.  
Si usted necesita esta carta en español, llame a un representante de Wasatch Mental Health al (801) 373-4760.

**Delete all information in Red before sending letter to client... *\*(This written Grievance decision letter is only required if the Grievance was filed in writing. It is optional for oral Grievances.)***

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]"

We received your \*Grievance on "[Click here and type date]" At the time your grievance was about  
**(summarize Grievance)**

***\*(if a provider filed the Grievance on Enrollee's behalf, adjust letter accordingly)***

We have decided **(summarize resolution)**.

If you have questions, call the Center's customer services representative at (801) 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: **Private provider (if applicable)**  
**Affected Parties (if applicable)**