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| **INSTRUCTIONS**: Please provide the information requested below to initiate your complaint. You can attach any additional pages you feel are necessary**.**  **For Standard Appeals**: We will not be able to process your appeal if a written/signed request is not received within 30 days of your verbal request. We will not be able to continue benefits during an appeal until a written/signed request is received. Please submit this form or send us an e-mail including this information to confirm your appeal in writing.  Send completed form to: Southwest Michigan Behavioral Health  Customer Services  5250 Lovers Lane, Suite 200  Portage, MI 49002  Or fax to: 269-441-1234  Or e-mail to: [info@swmbh.org](mailto:info@swmbh.org) | |
| Customer Name: |  |
| Customer phone number: |  |
| Customer address: |  |
| Date of complaint: |  |
| Customer Signature: |  |

My Grievance or Appeal is about:

|  |  |
| --- | --- |
| Provider/Agency/Staff Name | Service (s) |
|  |  |
|  |  |

Please describe why you are filing this complaint:

|  |
| --- |
|  |

What is your desired solution:

|  |
| --- |
|  |

Date Received by Customer Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Customer ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **Authorized Representative**  For an Appeal or Grievance, you can name someone to act for you.  If you would like to name a person/agency to act for you, please complete this page.  If you will complete the grievance or appeal on your own, you can leave this blank. | |
| Representative Name (please print): |  |
| Relationship to Customer: |  |
| Representative phone: |  |
| Representative address: |  |

**For the Customer:**

* By signing below, you agree that the named person/agency above will act on your behalf for the grievance or appeal stated on this form.
* By signing below, you authorize Southwest Michigan Behavioral Health to disclose your personal information to the authorized representative.
  + We will only release information that relates to the stated grievance or appeal.
  + If the Authorized Representative asks for information not related to the grievance or appeal, we will tell them that we need a full Release of Information (MDHHS-5515) signed by you.
* By signing below, you agree that the named authorized representative will receive any mail or calls related to your grievance or appeal instead of you.
* By signing below, you agree that when the grievance or appeal is resolved, they will no longer be your representative.
  + If you file a new grievance or appeal, you would need to complete this form again to name a representative.

Customer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the Representative:**

* By signing below, you agree to act on behalf of the named customer for the stated grievance or appeal.
* By signing below, you agree to receive personal information of the customer related to the grievance or appeal.
  + If you ask for information not related to the grievance or appeal, we will tell you that we need a full Release of Information (MDHHS-5515) signed by the customer.
* By signing below, you agree to receive any mail or calls related to the grievance or appeal instead of the customer.
* By signing below you agree that when the grievance or appeal is resolved, you will no longer be the customer’s representative.
  + If they file a new grievance or appeal and want you to represent them, we would need this form filled out again.

Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_