SPANISH

Complaint Process

The Addictions and Mental Health Division welcomes feedback on Oregon's behavioral health system of care.

- If you are dissatisfied with an experience, please complete and submit this form.
- This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact the Addictions and Mental Health Division at 503-945-5763, 711 for TTY, or email AMH.web@state.or.us.

You will receive a phone call within three business days to confirm your complaint was received and discuss any additional items needed before beginning an investigation.

- If your complaint is regarding the Oregon State Hospital, it will be referred to the Associate Director for Consumer and Family Services to be addressed.

If you have difficulty completing this form, please contact us at 503-945-5763 and we will assist you.

If you need help filing a complaint, please provide the following information:

Name: mjm - test

Address: _____

Phone: _____ Email: _____

Language I speak: _____

Let us know if you need:

- ☐ An interpreter
- ☐ A sign language interpreter
- ☐ Braille
- ☐ Large print
- ☐ Audio tape
- ☐ Computer disk
- ☐ Oral presentation

Red fields are required fields. The form can not be submitted until all required fields are completed.

This form may contain your personal information. If you return the form by email there is some risk it could be intercepted by someone you did not send it to. If you are not sure how to send a secure email, consider using regular mail or fax.

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Date complaint submitted:_____

Name of person submitting complaint:_____

Address:_____

Phone number:_____ Email: _____

☐ Prefer to remaining anonymous

☐ Please contact me

Note: Contact information is optional but is required if a response is desired.

Desired form of communication:_____

What days/times are most convenient for you to be contacted?

Day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time of day (*8:00 a.m.-5:00 p.m.*): _____

Are you a Medicaid recipient? ☐ Yes ☐ No

Type of plan: _____

Date(s) of event:_____

Describe the event or situation that generated the complaint:

Describe the desired resolution:

Have you attempted to resolve this situation with any other organization?

Print Reset Submit