

**GRIEVANCE PROCEDURE**

1. You or your authorized representatives have a right to submit a grievance to the Northland Counseling Center, Inc.
2. Within three business days of receiving a grievance, you will be acknowledged in writing that Northland Counseling Center, Inc. received the grievance.
3. If applicable, Northland Counseling Center, Inc. will include a notice of the appeal rights for a managed care organization's reduction, termination, or denial of a covered service.
4. Within 15 business days of receiving a grievance, a written final response to the grievance containing Northland Counseling Center, Inc. official response to the grievance will be mailed to the client.
5. The client is allowed to bring a grievance to the person with the highest level of authority in the program.
6. Staff will assist in every step of the grievance process as directed by the needs of each specific person.
7. Each grievance requires a written response from a member of Senior Management of Northland Counseling Center Inc. and may be reviewed by the Northland Board of Directors if the grievance cannot be resolved at the department level.

**Address grievances to any or all of the following resources:**

CCO and/ COO Director of Operations

Northland Counseling Center Northland Counseling Center

215 SE Second Avenue 900 Fifth Street, Suite 305

Grand Rapids, MN 55744 International Falls, MN 56649

218-326-1274 218-283-3406

Director of Chemical Dependency

Northland Recovery Center

1215 SE Seventh Avenue

Grand Rapids, MN 55744

218-327-1105

**Unresolved issues can be further addressed with:**

MN Dept. of Health MN Dept. of Human Services

O.H.F.C. State Licensor

393 North Dunlap Street, Box 64970 444 Lafayette Road

St. Paul, MN 55164-0970 St. Paul, MN 55155-3842

Office of Ombudsman for Mental Health & Developmental Disabilities

121 7th PL E. #420

St. Paul, MN 55101

**Licensing Boards:**

MN Board of Marriage and Family & Therapy MN Board of Behavioral Health & Therapy

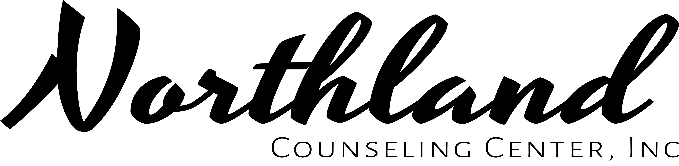
335 Randolph Ave. 335 Randolph Ave. Suite 290

St. Paul, MN 55102 St. Paul, MN 55102

MN Board of Social Work MN Board of Psychology

335 Randolph Ave, Suite 245 335 Randolph Ave, #270

St. Paul, MN 55102 St. Paul, MN 55102



**CLIENT GRIEVANCE**

DATE REPORTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STAFF INVOLVED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FACILITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE / TIME OF INCIDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE INCIDENT:

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FOLLOW-UP:

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SIGNATURE OF PERSON FILLING OUT FORM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF PERSON WHO COMPLETE FOLLOW-UP REVIEW:**

DIRECTOR OF OPERATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIEF COMPLIANCE OFFICER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIEF OPERATIONS OFFICER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIEF EXECUTIVE OFFICER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_