



# Mississippi Department of Mental Health Office of Consumer Support Grievance Form

Supporting a Better Tomorrow...One Person at a Time

**INSTRUCTIONS:** This form should be utilized by a person receiving services, their parent(s), or legal representative(s) for the purposes of filing a grievance against a DMH-certified provider. A grievance is a written, electronically submitted, or verbal statement made by a person receiving services (and/or parent(s)/legal representative(s)) alleging a violation of rights, policy, or a provider certification rule. (*Operational Standards Rule 14*). Please read carefully and complete this form. All attachments should be submitted with the completed form. Please type or print legibly. Original signatures must be included. If additional space is needed, please provide the information as attachments and reference the application section. The grievance should clearly set forth the charges to inform DMH and the certified provider of the issue involved. Incomplete forms or failure to respond to DMH requests for additional information may result in the dismissal of the grievance. Priority is given to grievances suggesting imminent harm. DMH will evaluate the grievance within 30 business days of receipt. Depending on the severity and investigation results, DMH may migrate the grievance to a complaint, including additional steps for complaints investigation and disposition. The form may be submitted in one of the following ways:

- o Electronically: Email the completed form to [ocs@dmh.ms.gov](mailto:ocs@dmh.ms.gov).
- o Mail: Send the completed form to: Office of Consumer Support; 239 N. Lamar Street, Suite 1001, Jackson, MS 39201.

### Section A

**Contact Information:** Please include the contact information for the person that is filing the grievance.

Name: \_\_\_\_\_ Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address (if not same as street address): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number (Primary): \_\_\_\_\_ (Secondary): \_\_\_\_\_

Email Address: \_\_\_\_\_

### Section B

**Grievance Details:** Fill out all sections of the form with accurate and detailed information.

Name of the Aggrieved Party: \_\_\_\_\_

Contact Information (Phone/Email): \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Name of DMH-Certified Provider: \_\_\_\_\_

Grievance Details/Statement of Grievance (Please describe the violation of rights, policy, or provider certification rule): \_\_\_\_\_

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**Section C**

**Waiver of Confidentiality:** By submitting a grievance, the party waives confidentiality as necessary for DMH to review the alleged violation.

**By submitting this grievance, I understand that I am waiving confidentiality as necessary for DMH to review the alleged violation.**

Signature

Date

Type or Print Name and Title of Individual Signing

**For DMH Use Only:**  
Received By: \_\_\_\_\_ Date: \_\_\_\_\_