



Grievance Tracking Form

(Upon completion of form, send to AQIS for Medi-Cal Beneficiaries only)

Grievance Information (complete in full)

Medi-Cal Beneficiary Name: Medi-Cal Status Verified: ☐ Yes ☐ No

Program Name: ☐ County ☐ Contract

☐ Adult and Older Adult Mental Health & Recovery Services [AOAMHRS]

☐ Children and Youth Prevention Mental Health & Recovery Services [CYPMHRS]

☐ Patients' Rights Advocacy Services [PRAS]

☐ Drug Medi-Cal Organized Delivery Systems [DMC-ODS]

Service Chief/Program Director:

Service Chief/Program Director Phone:

Date of Reported Grievance: Client Declined Grievance Process: ☐ Yes ☐ No

Grievance Resolved by End of Next Business Day: ☐ Yes ☐ No

Describe how the grievance was resolved:

Change of Provider Request: ☐ Yes ☐ No

Name of the provider that the client is requesting to change from:

Additional Information

Reporting Party Information

Clinical Staff Name: Clinical Staff Phone:

Date Form Completed: Time Form Completed: AM/PM

Important Information

You must complete
the Grievance or Appeal Form
in addition to this form.

Please send both the
Grievance or Appeal Form and Grievance Tracking Form
via [secure] email to AQISgrievances@ochca.com or fax to (714) 834-0775

For **questions**, please contact
AQIS main line:
714-834-5601