Complaint, Grievance and Appeal Policy

The WIN Team is committed to providing you with excellent care and high-quality Behavioral Health Services. However, we understand that some concerns may arise from time to time. Your constructive feedback is essential to ensure that you receive optimal psychiatric treatment and rehabilitation services.

WIN Team wants to resolve concerns fairly and quickly. Clients may file a complaint, grievance, or appeal at any time.

Steps to Follow

Step 1: Speak with your assigned worker about the concern.
Step 2: If unresolved, request and complete a Grievance Form.
Step 3: A copy will be placed in the client record and sent to the Program Director.
Step 4: The Corporate Compliance Officer will investigate within three business days.
Step 5: Staff will report findings to the Corporate Compliance Officer.
Step 6: If unresolved within five business days, a meeting may be scheduled with the client, team members, and involved parties.
Step 7: If still unresolved, WIN Team will provide information for higher-level review through the appropriate agency.

Primary WIN Contacts

Tracey Drummond, Corporate Compliance Officer: 410-578-8003 | tdrummond@winfamilyhealth.com
Dawn James, LCSW-C/LCADC, Clinical Director: 410-578-8003 | djames@winfamilyhealth.com
Complaint email: complaint@winfamilyhealth.com

Client Complaint, Grievance and Appeal Form

Directions: Our records show that we reviewed the Client Complaint & Grievance and Appeal Policy and the Client Rights and Privileges as a WIN Team Client Policy during your orientation meeting. Please complete this form as thoroughly as possible to fully describe your complaint or grievance. WIN Team Staff can support you, if needed. Anticipate a written response within 30 days.

WIN Team Contact Person	
Program Director Tracey Drummond, Corporate Compliance Officer 410-578-8003 or tdrummond@winfamilyhealth.com	**Clinical Director** Dawn James, Corporate Compliance Officer 410-578-8003 or djames@winfamilyhealth.com

Client Name		**Medical Assistance#**		**Date of Birth**	
Date of Complaint		**Time of Complaint**			
WIN Team Staff Involved					

Description of Incident (Attach additional page as needed):

Desired Resolution:

List other individuals you want to include to support your position:

Do you have supporting documentation that validates the evidence of the complaint and actions taken?

☐ **YES (Please attach)** ☐ **NO**

Would you like WIN's Core Service Agency (CSA) to review your complaint and WIN's determination?

☐ **YES** ☐ **NO**

	Printed Name	Signature	Date
Client			
WIN Representative			

WIN's Follow-Up Determination Anticipated Date: _____