

# NEW PERSPECTIVES CENTER COMPLAINT FORM

DATE \_\_\_\_\_

Client Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Fill in your name if you are filing this complaint for the client named above*

Complainant Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please describe your complaint in detail. You can use more paper if necessary.**

*I have a complaint about* \_\_\_\_\_

**Please describe how you would like your complaint to be resolved.**

**Check here if you need an urgent response, you must explain below**

*The agency will determine whether the situation requires immediate attention to prevent serious jeopardy to your life, health or ability to function. For all urgent complaints, the agency will respond within 48 hours.*

**Explain why this complaint is urgent:**

**Consumer Signature** \_\_\_\_\_

*Your signature indicates that you are making a formal complaint. If someone else is filing this complaint, your signature allows the complainant to file this complaint for you and to exchange information with the agency.*

**Complainant Signature** \_\_\_\_\_

*Your signature indicates that you are filing this complaint with the consumer's consent (the consumer must also sign) or that you have the authority to file this complaint on their behalf without the consumer's consent (you must include proof).*

You can use this form to file a complaint about services at New Perspectives Center. Please return this form to:

New Perspectives Center  
ATTN: Director  
1675 Winter Street NE  
Salem, OR 97301

If you have questions call the agency at: (503) 316-6770

You can also file a complaint and/or the complaint form with your health plan or the Health Systems Division Plan directly. Please check your OHP card to see which plan is listed:

PacificSource Community Solutions CCO	541-382-5920	
InterCommunity Health Network CCO	541-768-4550	1-800-832-4580
Yamhill County CCO	503-434-7523	
Health Systems Division	503-945-5763	

When you sign the complaint form, you allow the agency to investigate and share information for the purpose of resolving your complaint. You can ask someone to be a complainant for you. You will both have to sign the form. Only the people who have the legal authority to make medical decisions for you can file a formal complaint for you without your signature.

Agency use only: Agency _____	OHP <input type="checkbox"/>
Entered into Log: _____	Final disposition entered into Log _____
Consumer authorizes complainant to speak for them <input type="checkbox"/> yes <input type="checkbox"/> no	
Received By _____	Date _____
<b>Urgent Request</b>	
Request <input type="checkbox"/> Yes <input type="checkbox"/> No    Confirmed <input type="checkbox"/> Yes <input type="checkbox"/> No	
Confirmed by _____	Notified Complainant Date _____
Continued Benefits/Services <input type="checkbox"/> Yes <input type="checkbox"/> No	
Acknowledgement Date _____	Response Date _____