Client Concern Form

Benton County Health Services

We understand that you have a concern or complaint about the services you received. Please complete this form clearly, and return it to the receptionist or mail it to:

Benton County Health Services
Attention: Compliance Manager
P.O. Box 3020, Corvallis, OR 97339-3020

Date of incident: _____

Name of person(s) involved: _____

Program(s) involved:

☐ Primary Care ☐ Dental ☐ Behavioral Health ☐ Home Visiting ☐Immunizations
☐ WIC ☐ Environmental Health ☐ Other: _____

Name of person submitting the concern/complaint: _____

Phone number:_____

Statement of concern/complaint:_____

_____

_____

(Use additional paper if needed)

What do you want/expect to happen? _____

_____

_____

Would you like to be contacted regarding your concern or complaint?

☐ **Yes**, I would like to be contacted. Address: _____

☐ **No**, I do not wish to be contacted.

For Oregon Health Plan Members: If you wish to file your complaint directly with the IHN-CCO complaint line or you are not satisfied with our response, you may call 541-768-4616.

Printed Name	Signature	Date

****Office Use Only****

Outcome: _____

_____

Staff Signature _____ Date _____