

CONFIDENTIAL - CLIENT SERVICE EVALUATION

Ryan White service agencies welcome your comments & appreciate the use of their grievance procedures. All clients are encouraged to use the grievance procedures at the agency where the service was received. If the client is unable to use the agency's grievance procedure for any reason, then this service evaluation form is used.

- **My experience with the agency listed below was:** Satisfactory Unsatisfactory

If you checked "Unsatisfactory" above, have you filed a grievance at the agency?

- Yes No Not Applicable

- **I am (check one):** Living with HIV/AIDS Caregiver/ Affected Individual/ Advocate

Name (optional) _____ **I want to be contacted** Yes No

Phone number _____ **Best time to call** _____ AM PM

Primary Phone () - **OK to leave message?** Yes No

- **I give permission to share my name / information to process this evaluation** Yes No

▪ **Name of agency where service was received:** _____

▪ **Date of service:** _____ **Name of staff person (if known):** _____

▪ **Type of service received:** _____

RELEASE OF CONFIDENTIALITY

I hereby authorize the San Diego County Health and Human Services Agency to contact the above named agency to obtain any information or materials that are deemed necessary to resolve my written concerns. If I don't want my information shared, a copy of this complaint with **my name** blocked out may be sent to the agency where the service was received. This release will be used only for the issue described on this form and will not exceed sixty (60) days.

Signature

Date

COMMENTS (Please describe the nature of the service received, attach additional sheets if necessary.)

HOW THE PROCESS WORKS

1. A member of the Clinical Quality Management (CQM) staff at the HIV, STD and Hepatitis Branch will process this service evaluation. If the client wishes to be contacted, the CQM staff will reach out to them within three (3) business days of receiving this form. The client will be asked for additional information (if needed) and asked if the client is comfortable sharing their name with the agency. CQM staff will send this information to County staff for processing and providing feedback to the agency.
2. County staff will contact the agency to report the issue. The agency will be asked to respond to the client either directly or through County staff, and to follow-up in writing to CQM staff within thirty (30) days describing the resolution.

Mail the completed form to:
COUNTY OF SAN DIEGO, HSHB
3851 Rosecrans Street, MS: P505
San Diego, CA 92110-3115

OR

Email an electronic version to:
OAC.HHSA@sdcounty.ca.gov