☐ CONCERN ☐ COMPLAINT ☐ GRIEVANCE ☐ VERBAL ☐ WRITTEN

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| --- | --- | --- |
| Receiver of form: | | Date: |
| Name of Complainant: | | |
| Address | | Telephone No. |
| **ISSUE** | | |
| 🞏 Eligibility/Intake  🞏 Accessibility to Care  🞏 Quality of Care  🞏 Appropriateness of Care | 🞏 Financial Problem  🞏 Staff Attitude  🞏 Facility Environment  🞏 Continuity of Care | 🞏 Client Rights Issue  🞏 HIPAA, Confidentiality, PHI Issue  🞏 Staff Code of Conduct  🞏 Other |
| **PROBLEM SUMMARY** | | |
| Include date of incident, staff name if relevant, and what the writer or caller wants. | | |
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| **IMMEDIATE ACTION STEPS** | | |
| DATE ADDRESSED: | | |
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| **RESOLUTION** | | |
| DATE RESOLVED: | | |
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| DID COMPLAINANT APPEAR SATISFIED WITH RESOLUTION? 🞏 YES 🞏 NO | | |
| If not, why? | | |
| If NO, WAS COMPLAINANT INSTRUCTED TO SUBMIT A FORMAL COMPLAINT/GRIEVANCE IN WRITING? 🞏 YES 🞏 NO | | |
| **ACKNOWLEDGEMENT** | | |
| VERBAL CONCERNS: CALL BACK DATE: SPOKE TO: | | |
| WRITTEN CONCERNS/COMPLAINTS/GRIEVANCES: ACKNOWLEDGMENT LETTER PROVIDED: NAME AND DATE | | |
| **NOTIFICATION / SIGN OFF** | | |
| SUPVR. NOTIFIED? NAME DATE | | |
| PERSON CONTACTED FOR QUALITY OF CARE ISSUES (PROGRAM DIRECTOR, CLINICAL DIRECTOR CLINICAL SUPERVISOR) DATE | | |
| COMMENTS | | |
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| REVIEWED BY: DATE | ADMINISTRATOR DATE | QUALITY IMPROVEMENT DATE |