GRIEVANCE FORM

You can choose to give this form to any LLC staff person or an advocate (list of advocates posted in the lobby of each program). If you are concerned about submitting a complaint to staff where you are receiving services, you can request an envelope, seal it and label it to the "Quality Assurance Specialist."

Today's Date / / / / / / / / /	Date of Incident/ Date of Incident/		
Patient Name	First	Middle	
Contact Info			
Home phone	Cell Phone	Email	
Insurance Provider: Molina/Beacon/CHPW	Private Insurance/Self Pay 🗌 Bl	HO:	
Who, if anyone, was incident reported to:	Date Reported:		
Grievance Type			
☐ Quality	Quality of service received is not adequate and/or appropriate to meet patient/family needs.		
☐ Access to Services	Patient is unable to access service or unable to access within needed timeframe (do no include access to prescriber). Concern about admissions process, denial of services or language barriers.		
☐ Follow up services	Phone calls not returned by agency staff and/or not returned in a timely manner.		
☐ Service - Intensity, Not Available, Coordination	The desired service is not available, or not available in the frequency desired, and/or is not coordinated with other services.		
Rights	Violation of individual rights.		
☐ Medical Services	Any concern involving prescriber or medications, including timely access to medical staff and medication.		
Financial & Admin. Services	Concern about financial or administrative svcs (e.g. policies & procedures, financial eligibility, charges).		
☐ Dignity and Respect	Patient/family not treated with dignity and respect.		
☐ Violation of Confidentiality	Personal health information shared without consent or beyond "need to know".		
☐ Individualized treatment	Concern about lack of input in service plan goals or service options.		
☐ Food/Health/Safety	Related to residential programs cleanliness and overall safety.		
☐ Personal Property	Concern about care of personal property.		
☐ Housing	Assistance with obtaining or maintaining housing.		
☐ Transportation	Issues related to transportation that are agency related.		
Other:	Any concern that does not fall into a category listed above.		
Person and/or Department the complaint is direct	ted toward		
	or		
Staff Name	or Department/Unit		

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What was the outcome when you spoke to the pr		
If you have not spoken to the program staff abou	t your concerns/complaint, what is	the reason?
What would you like to see happen to make the s	situation better? Attach a separate shee	et of paper if additional space is
Name of Patient or Representative submitting form	Phone number	Date
FOR OFFICE USE ONLY		
Received by: LLC Staff Name:	Date:	

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