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” or email to "grievances@lifelineconnections.org".

Today’s Date _ _/_ _/_ _ _ _ (M M DD YYYY) **Date of Incident** _ _/_ _/_ _ _ _ (M M DD YYYY)

Patient Name ______________________ ______________________ ____________
Last First Middle

Race American Indian or Alaskan Native ☐ White or Caucasian ☐ Black or African American ☐ Asian or Pacific Islander ☐ Hispanic or Latino ☐ Other Race ☐

Contact Info ____
Home phone Cell Phone Email

Insurance Provider: ☐ Molina/Beacon/CHPW ☐ Private Insurance/Self Pay ☐ BHO:____________________

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 not 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.
☐ Administrative Services	Concern about administrative services (e.g. policies & procedures)
☐ Dignity and Respect	Patient/family not treated with dignity and respect.
☐ Breach of Protected Health Information	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.
☐ Non-Compliant Business Operations	Concern of staff member violation of ethics, WACs, providing services out of scope or violation of safety
☐ Fraud/Waste/Abuse	Concern about billing, financial or patient services.
☐ Other: ____________________	Any concern that does not fall into a category listed above.

Person and/or Department the complaint is directed toward

______________________________ or ______________________________
Staff Name Department/Unit

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Describe the nature of complaint or concerns for all types of complaints. Please describe the problem with names, dates, and location. List any facts to support the complaint. Attach a separate sheet of paper if additional space is necessary.

What was the outcome when you spoke to the program staff about your concerns/complaint?

If you have not spoken to the program staff about your concerns/complaint, what is the reason?

What would you like to see happen to make the situation better? Attach a separate sheet of paper if additional space is necessary.

Name of Patient or Representative submitting form | Phone number | Date

FOR OFFICE USE ONLY

Received by: LLC Staff Name: ____ Date:________________________________