

GRIEVANCE FORM

You can choose to give this form to any Lifeline Connections staff person or an advocate. 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 / /
MM DD YYYY

Date of Incident / /
MM DD YYYY

 Anonymous Patient Name _____
Last First Middle

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

Gender Identity	Prefer not to disclose	Agender	Genderfluid	Gender Non-conforming	Transgender Male
	Male	Bigender	Genderqueer	Non-binary	Transgender Female
	Female	Intersex	My gender is (if not listed) :		
	Two Spirit	Non-binary			

Contact Info _____
Home Phone Cell Phone Email

Insurance Provider: Molina / Carelon / CHPW Private Insurance / Self Pay Other _____

Who, if anyone, was your grievance reported to? _____ Date Reported: _____

Grievance Type

<input type="checkbox"/>	Quality.....	Quality of service received is not adequate and/or appropriate to meet patient/family needs
<input type="checkbox"/>	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.
<input type="checkbox"/>	Follow-up Services.....	Phone calls not returned by agency staff and/or not returned in a timely manner
<input type="checkbox"/>	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.
<input type="checkbox"/>	Rights.....	Violation of individual rights.
<input type="checkbox"/>	Medical Services.....	Any concern involving prescriber or medications, including timely access to medical staff and medication.
<input type="checkbox"/>	Administrative Services.....	Concern about administrative services (e.g. policies & procedures).
<input type="checkbox"/>	Dignity / Respect.....	Patient/family not treated with dignity and respect.
<input type="checkbox"/>	Breach of Protected Health Information.....	Personal health information shared without consent or beyond "need to know".
<input type="checkbox"/>	Individualized Treatment.....	Concern about lack of input in service plan goals or service options.
<input type="checkbox"/>	Food / Health / Safety.....	Related to residential programs cleanliness and overall safety.
<input type="checkbox"/>	Personal Property.....	Concern about care of personal property.
<input type="checkbox"/>	Housing.....	Assistance with obtaining or maintaining housing.
<input type="checkbox"/>	Unit Safety and Habitability.....	Failure to meet basic safety and habitability standards.
<input type="checkbox"/>	Transportation.....	Issues related to transportation that are agency related.
<input type="checkbox"/>	Non-Compliant Business Operations.....	Concern of staff member violation of ethics, WACs, providing services out of scope or violation of safety.
<input type="checkbox"/>	Fraud / Waste / Abuse.....	Concern about billing, financial or patient services
<input type="checkbox"/>	Other: Any concern not listed above.	_____

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Person and/or Department the grievance is directed toward –

_____ and / or _____
Staff Name Department / Program

Describe the nature of complaint or concerns for all types of complaints. 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.

Signature of Patient / Representative submitting form _____ Phone Number _____ Date _____

Agency Use Only

Grievance Received by _____
Staff Name Department / Program Date

STAFF: Upon receipt, submit ALL Grievances IMMEDIATELY by scanning to GRIEVANCES email group.
(Do not place in QA staff mailbox)