# Grievance Report Form

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| **Participant’s Name:**  | **Date of Grievance:** |

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| **Individual Filing the Grievance:**  | **Name and Contact Information:** |
| * Participant (not required)
 | (Name/Relationship to Participant) |
| * Staff on behalf of participant
 | (Address) |
| * Family Member
 | (Email) |
| * Participant’s Representative
 | (Telephone) |

**Please provide a complete description of your grievance: What happened, what date did the grievance occur, who was involved, and where did the incident occur?**

**Signature of Person Reporting the Grivance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

*I have been advised of my right to ask for help in filing my grievance. I have received written information about the grievance process. \_\_\_\_\_\_\_\_\_\_\_\_ (please initial). I have designative the above person to act as my representative and to assist me in this process. \_\_\_\_\_\_\_\_\_\_\_ (if applicable).*

**For Internal Use Only**

**Date Report Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program Director, or designee, noticed of grievance by telephone or email: Date \_\_\_\_\_\_\_\_\_\_\_**

**Program Director, or designee, documented receipt of grievance in the Grievance Log: Date \_\_\_\_\_\_\_\_**

**Siyan Staff telephoned acknowledgement of receipt to participant, (or their representative):**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_**

**Siyan Staff sent a written acknowledgement to participant within 5 business days of receipt of grievance. Date: \_\_\_\_\_\_\_\_**

**The CEO is notified of any grievance concerning medical or urgent care. Date: \_\_\_\_\_\_\_\_**

**Thirty calendar days** from the day the grievance was received, either:

* The grievance has been resolved. The Program Director, or designee, has provided the participant with a report describing the problem’s resolution, the basis for the resolution, and the review process if grievance is unresolved. **Date Sent: \_\_\_\_\_\_\_\_\_\_\_**
* The grievance response is pending or delayed. The Program Director, or designee, provides a brief written report explaining the reason(s) for the delay to the participant or their representative. **Date Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expedited Review: If the grievance involves an imminent and/or serious threat to the health of the participant.**

* The participant and/or their representative are immediately notified by telephone of the receipt of the request for an expedited review: **Date: \_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_**
* The participant and/or their representative are informed of their rights to notify CMS and DHCS of the grievance.
* No later than 3 business days from receipt of the grievance, a written statement of the final disposition or pending status of the grievance is sent to the participant, and or representatives, CMS, and DHS.

**Comments/Additional Info:**

**Regulatory and Source Citation:**

Title 22 California Code of Regulations Adult Day Health Care § 54407 and Adult Day Health Care Centers §78437(a)(8)

Department of Health and Human Services, CMS, Federal Register Volume 64, No. 226, 42CFR Part 460.120, 124;

California Department of Health Services Contract

PACE Grievance Report Template, 2022.