

Grievance Report Form

Participant Name (<i>Last Name, First</i>):	
Date:	Member ID:
Individual filing the grievance: <input type="checkbox"/> Participant <input type="checkbox"/> IIH staff on behalf of participant <input type="checkbox"/> Contracted Provider <input type="checkbox"/> Participant's Representative* <input type="checkbox"/> Other* <i>*fill out contact information</i>	Contact Information: <i>(complete only if non-participant):</i> Name: _____ Relationship: _____ Phone: _____ Address: _____ <i>*Electronically available upon request</i>
Name/Job Title of IIH Staff receiving the grievance:	
Department:	

Type of Grievance (*Choose all that apply*)

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Activities | <input type="checkbox"/> Enrollment | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Home Care | <input type="checkbox"/> Disenrollment |
| <input type="checkbox"/> Contracted Facility | <input type="checkbox"/> Marketing | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Contracted Specialist | <input type="checkbox"/> Medical Care | |
| <input type="checkbox"/> Dietary | <input type="checkbox"/> Medication | |
| <input type="checkbox"/> PACE Services | <input type="checkbox"/> Supplies | |

Please provide a complete description about your grievance below.

Date(s) Occurred: _____

Location(s) Occurred: _____

IIH Staff Involved: _____

Description of Events (*Continued on next page if necessary*):

Check here if you have used additional pages and they are attached.

When completed, please return this form and any additional pages to Quality Improvement (QI) Department by utilizing the QI drop box or send it via secured email.

Name & Signature (Grievance Report completed by): _____

Description of Events *(Continued if applicable):*
