WelbeHealth Bay Area PACE, LLC (dba WelbeHealth)
1799 Hamilton Avenue
San Jose, CA 95125
(888) 275-5240

GRIEVANCE REPORT

Date: Date

Participant's name: Name of participant/representative

1. Individual filing the grievance:

☐ Participant (not required)
☐ Enter Site and Staff Name on behalf of participant
☐ Family member or participant's representative (please complete section 2)

2. Name and contact information: (if other than participant or staff)

Name/Relationship to Participant: Name of participant/representative

Address: Address

Telephone: Phone#

Please provide a complete description about your grievance: What happened? Who was involved? What date did the event occur? Where did the event occur? *If you need more space, please attach additional pages.*

☐ *Check box if additional pages are attached* .

Description of Grievance

Name: Name of representative **Date:** Date.
Signature of Person Reporting Grievance:

I, Name***, offered the participant the option of filing a grievance, but the participant declined.***

Please note: Participants are not required to sign or initial this form.

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 if correct).

I have designated the above person to act as my representative and to assist me in this grievance process. _____ (if applicable, participant initials).

I was offered to file a grievance and I declined to file one at this time. _____ (please initial if correct)

If applicable, please indicate the **WelbeHealth staff name** assisting to complete this form: **_____**

When completed, please give this report to your Social Worker or any other member of your WelbeHealth care team OR mail to:

WelbeHealth
Quality Improvement Department
1799 Hamilton Avenue
San Jose, CA 95125

For Internal Staff Use Only

Date Report Received by QI: Date

☐ **Quality Improvement (QI) Department notified of the grievance or declination by e-mail.**
Date: Date

☐ **Report received by the QI Department.**
Date: Date

☐ **QI Staff documented receipt of grievance or declination into Grievance Log.**
Date: Date

☐ **QI Staff telephoned acknowledgement of grievance receipt to Participant (within 5 days).**
Date: Date **Time**: Time

☐ **QI Staff sent a written acknowledgment to participant (within 5 days).**
Date Sent: Date sent

☐ **Medical Director is notified of the grievance concerning medical care or urgent grievance.**
Date: Date

☐ **Director responsible for services or operations is notified of the grievance.**
Date: Date

30 calendar days from the day the grievance was received, either:

☐ The grievance has been resolved. The QI Coordinator has sent the participant a report describing the problem's resolution, the basis for the resolution, and the review process if dissatisfaction continues. **Date Sent**: Date

OR

☐ The grievance is pending. The QI Staff sent a report with a brief explanation of the reasons for the delay to the Participant and/or his/her representative.
Date Sent: Date

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

☐ **The participant and/or representative are immediately notified by telephone of the receipt of the request for an expedited review.**

Date: Date **Time**: Time

☐ **The participant and/or representative are notified of their right to notify CMS and DHCS of the grievance.**

☐ **No later than 3 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 representative, CMS and DHCS.**

Comments:

Click or tap here to enter text.