



WelbeHealth
46805 Dune Palms Road
La Quinta, CA 92253
888-530-4415

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:

Inland Empire
Quality Improvement Department
46805 Dune Palms Road
La Quinta, CA 92253

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.