Patient Complaint or Grievance Form

Klamath Tribal Health & Family Services

Patients have the right to file a grievance regarding treatment or care that is (or fails to be) furnished or file a complaint about KTHFS or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. All complaints are confidential and will be given serious attention. This patient complaint form will be routed to the appropriate Clinical Program Director and/or Department Manager, who will directly address your concern. For additional information, please contact the Quality Assurance Specialist.

GENERAL INFORMATION	
Complaint received by:	
Date & Time of Complaint:	
How complaint was initially made or delivered:	□ e-mail □ in person □ phone □ in writing □ via another person: e.g., KTHFS Employee, HAC, TC
Name of person **making the complaint?** Relationship to the Patient? □ Self □ Other; if other, please state relationship:	
Patient Name	
Address (Required Field)	
Phone number(s) & email	
ABOUT THE COMPLAINT	
Program or Department involved	
Staff involved [include name/title]	

SUMMARY OF PROBLEM OR REASON FOR COMPLAINT (ATTACH ADDITIONAL SHEETS OF PAPER, IF NEEDED).
Summary:
Client Signature/Date:

FOR OFFICE USE ONLY

COMPLAINT TYPE	DESCRIBE ISSUE
☐ **Access to Care**	• Excessive wait time in the lobby or exam room • Takes too long to get an appointment • Other:
☐ **Clinical: Program Operations**	• Appointment scheduling issue • Did not receive lab/test results in a timely manner • Prescription refill issue • Referral process • Other workflow issue:
☐ **Clinical: Quality of Care**	
☐ **Disagrees with Purchased/Referred Care policy** ☐ **Disagrees with Resource Committee decision**	
☐ **Facilities**	• Housekeeping issue • Patient safety or security issue • Other:
☐ **Individual with Multiple Complaints** ☐ **Repeated or Previously Unresolved Complaint**	
☐ **Pain Management Issue**	
☐ **Personal Interaction with an employee/staff**	• Poor communication • Rude and/or unprofessional behavior • Other:
☐ **Other**	
ROUTE TO:	
☐ Administration (KTHFS)	☐ Patient Registration
☐ Behavioral Health (YFGC)	☐ Pharmacy
☐ Dental	☐ Purchased/Referred Care
☐ Health Education	☐ Transportation
☐ Medical, please specify: Medical Director, Nursing Supervisor, Medical Office Manager	☐ TES ☐ Other
FOR USE BY ADMINISTRATION:	
Date the Patient Complaint was logged. Date: ____________________________	Complaint Number:
Follow up with Dept. Manager to determine whether or not complaint was addressed? Date: __________ Follow up by: ☐ E-mail ☐ Phone ☐ In-Person	Was an 'Action Letter' was mailed out to patient? ☐ Yes ☐ No ☐ N/A Date: ______________________
Date the file complete with all documentation. Date:_______________________	Date the complaint was sent to HGM for approval: Date:__________________

CONFIDENTIAL

Sections 1 & 2 must be completed by Director or Manager within 10 days: Must be signed and dated.

1. Describe action(s) taken by the Program Director or Department Manager to resolve issue. Attach additional sheets if needed.

2. Was issue resolved? □ Yes □ No. If not, give reason(s) why not.
   □ Complaint was addressed; however, not resolved to patient's satisfaction.

3. **Director/Manager Signature/Date**

For Administration Use Only:

Follow-up phone call /letter made to patient? Yes, By: No (none required)
QAS - Signature Date sent to HGM for review/Signature:

NOTES:

HGM Signature/Date