# 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<br>□ phone □ in writing<br>□ via another person: e.g., KTHFS Employee, HAC, TC |
| Name of person **making the complaint?**<br>Relationship to the Patient?<br>□ Self<br>□ Other; if other, please state relationship: | |
| Patient Name | |
| Address ( Mandatory as we send letter) | |
| 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).** |
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| **Client Signature/Date:** |

## FOR OFFICE USE ONLY

| COMPLAINT TYPE | DESCRIBE ISSUE |
|---|---|
| □ **Access to Care** | • Excessive wait time in the lobby or exam room<br>• Takes too long to get an appointment<br>• Other: |
| □ **Clinical: Program Operations** | • Appointment scheduling issue<br>• Did not receive lab/test results in a timely manner<br>• Prescription refill issue<br>• Referral process<br>• Other workflow issue: |
| □ **Clinical: Quality of Care** | |
| □ **Disagrees with Purchased/Referred Care policy**<br>□ **Disagrees with Resource Committee decision** | |
| □ **Facilities** | • Housekeeping issue<br>• Patient safety or security issue<br>• Other: |
| □ **Individual with Multiple Complaints**<br>□ **Repeated or Previously Unresolved Complaint** | |
| □ **Pain Management Issue** | |
| □ **Personal Interaction with an employee/staff** | • Poor communication<br>• Rude and/or unprofessional behavior<br>• 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 | □ Public Health<br>□ Other |
| **FOR USE BY ADMINISTRATION:** | |
| Was the patient complaint logged according to policy? □ Yes □ No Date: _____________ | Complaint Number: |
| Was an 'Action Letter' was mailed out to patient? Keep a copy on file. □ Yes □ No Date: _____________ | Was a copy of the 'Action Letter' forwarded to the Department Manager for full/final resolution?<br>□ Yes □ No Date: _____________ |
| Follow up with Dept. Manager to determine whether or not complaint was addressed? Date: ___________<br>Follow up by: □ E-mail □ Phone □ In-Person | Was a documented response by the Department Manager included in the Patient Complaint File?<br>□ Yes □ No Date: _____________ |

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## FOR USE BY PROGRAM DIRECTOR OR DEPARTMENT MANAGER:

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

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

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3. Final follow-up phone call made to patient/client?
   ☐ Yes, by: ____________________Response_______________________________________
   ☐ No, not required

| FOR USE BY KTHFS ADMINISTRATION |
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| Quality Assurance Specialist or Designee Signature / **Date:** |
| Health General Manager or Designee Signature / **Date:** |

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