ENCOMPASS HEALTH HOME

Care Management

Complaint Form

As a Participant of Encompass Health Home, you have the right to make a complaint regarding your Health Home services, and or violations of your Participant rights. Encompass Health Home, will not engage in any discriminatory or other retaliatory behavior against you because of this complaint. Please be as thorough and forthright as possible, and return this form to_____.

Participant/Guardian Name:
Address:
Phone:
E-mail Address:
Preferred method of contact?
Best time to be reached?
Date of alleged occurrence:
Date complaint was made:
Person who received the complaint:
Care Management Agency:
Name of Care Manager:

Details of the complaint: *(Please be as specific as possible with dates, times and the specifics regarding the complaint; discuss any action taken thus far; include the names, if any, of anyone in the agency with whom you have discussed this. Attach additional pages to this form if you need more room. Attach any documents that you believe pertain to this complaint.)*

___ Documents are attached (describe below):

_____

Participant/Guardian Name (print): _____

Participant/Guardian Signature: _____

Date: _____

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If not completed and signed by the Participant, indicate relationship below:

Name of Individual who completed form: _____
Phone Number: _____

Relationship to Participant:

- ☐ Parent/Guardian; Family Member of Participant
- ☐ Friend/Advocate
- ☐ Care Manager/Health Home Staff
- ☐ Provider
- ☐ Other (specify) _____

FOR OFFICE USE ONLY:

Date Received: _____ Time: _____
Notifications Made:
☐ DOH Date: _____
☐ Care Management Program Date: _____
☐ Lead Health Home Date: _____
☐ Other: _____ Date: _____
Complaint Processed/Investigated by: _____
Investigation Completion Date: _____
Outcome/Action Taken:

_____
_____
_____

Participant/Guardian Notified of Outcome (Date): _____
By Whom: _____
Participant/Guardian satisfied with outcome: ☐ Yes ☐ No
If No, additional steps to be taken:

_____
_____
_____