ENCOMPASS HEALTH HOME

Complaint Tracking Form

Month _____ **Care Management Agency** _____

Date/Time of Complaint	Participant's Name	Investigation Assigned To:	Date Investigation Concluded	Outcome	Appropriate Notification(S) Made (Y-N)	Needed Corrective Action	Date/Time Reported to Health Home (if applicable)	CMA/Health Home Disposition: Corrective Action Completed-Issue Resolved (✓)	Participant Notified (DATE or N/A)