

NorthCare Customer Services Complaints/Grievance Tracking Form for SA

Name of Caller _____ Phone #: _____ Relationship/Organization _____
Consumer _____ Consumer Phone #: _____
DOB: _____ Medicaid Yes _____ No _____ Medicaid #: _____
Board: _____ Site/Program: _____
County: _____
Source/Complainant: Consumer Family/Guardian Provider
 Community Member Other Staff
Population: SMI SED DDA DDC SA Other
Received Information Via: Phone, Face-to-Face, Written, Other
Staff Receiving Complaint: _____
Date of Complaint Received: _____ Time _____ am/pm
Reference # _____ Year/month/day/NP/consumer initials) Reference # **ONLY** needed if **NOT** a Medicaid Recipient

NATURE OF THE INQUIRY/COMPLAINT:

- Access Issue:** Anything that prevents access. Ex: parking, timeliness of appointment, transportation, barriers to the building, stigma, concerns about quality of care, not knowing who to call, etc.
- Financial Issue:** Billing concerns, budget issues, determination of ability to pay, insurance concerns and more.
- Respect Issue:** Anything that is not a rights issue that concerns equality, fairness, and being courteous
- Treatment Issue:** Any non-rights issue that someone has about their treatment. Ex: lack of a male or female therapist.
- Suggestion Issue:** Solution oriented comments or positive suggestions.

Specific Concern: (Use back of form if needed.) _____

Date Issue Occurred: _____ Time: _____ a.m./p.m.
Address of Consumer or Guardian: (MUST FILL IN IF MEDICAID)

RESOLUTION PROCESS:

IF MEDICAID recipient, fax (906) 225-5149 to Sally Olson within 24 hours of receiving complaint.

IF Referred to Recipient Rights (Tracking will be the responsibility of the Recipient Rights Department)

Date Forwarded _____ Forwarded By _____

IF Non-Medicaid Recipient: Substance Abuse Agency Internal Resolution Process:

Parties involved in resolution:

Name	Title
_____	_____
_____	_____

Date of FINAL resolution: _____ Date of disposition mailed: _____

Summary of Resolution: _____

