PROCEDURES FOR PATIENT GRIEVANCE and COMPLAINT PROCESS

Any patient who has a grievance should follow the procedure listed below. A patient may grieve or complain on any matter or subject that he/she believes has been handled improperly or they are not in agreement with.

The purpose of this policy is to establish a written procedure for patient grievances and complaints. This policy will ensure that patient grievances/complaints are given full and fair consideration to the highest level of appeal.

To file a complaint or a grievance, forms will be made available at all Health Division facilities at the main reception areas.

Who To Contact	Explanation	Recommended Time To Contact This Person
FIRST: EMPLOYEE	Each patient should discuss the problem with the employee involved. If a satisfactory resolution is not obtained, then that employee should refer the patient immediately to his/her supervisor.	SAME DAY
SECOND: SUPERVISOR	The employee, supervisor, and patient should discuss the matter and try to reach a resolution. If a satisfactory resolution is not obtained, then the supervisor should contact the Program Manager.	SAME DAY
THIRD: PROGRAM MANAGER	The Program Manager and the patient should discuss the matter and try to reach a resolution. If a satisfactory resolution is not obtained, then the Program Manager should contact the Health Director. (An appointment may be needed)	(3) DAYS
FOURTH: RECIPIENT RIGHTS OFFICER	The Recipient Rights Officer may be involved if the complaint is centered around an alleged violation of patient rights. (An appointment may be needed)	(3) DAYS
FIFTH: HEALTH DIRECTOR	The Health Director and the patient should discuss the matter and try to reach a resolution. If a satisfactory resolution is not obtained, then the Health Director shall make a decision as Governing Director.	Up to (10) BUSINESS DAYS
GOVERNING DIRECTOR	The Governing Directors Decision time frame is included in the (10) Business days of the Health Director time frame indicated above.	

*** POST IN ALL HEALTH DIVISION BUILDINGS ***

Centers for Medicare & Medicaid Services

Toll-Free: 800-MEDICARE

Sault Tribe Health Division Grievance /Patient Complaint Form

Name of Site/Facility:	Date of Incident:			
Department Incident Occurred In:	Time Incident Occurred:			
Person Registering the Complaint:	Name of Employee(s) Receiving Complaint:			
Address of person registering the complain	nt:			
Phone Number Contact Information:				
Home:				
Cell:				
Nature of Incident: (Please Provide a brief	f description of the incident)			

Patient Complaint Resolved by: (please indicate by circling)						
Employee	Supervisor	Physician	Manager	Health Director		
Date Grieva	ance / Compla	int process co	ompleted:			
Patient Grie Yes	evance /Comp No		d to the Satisfac	ction of the Patient: ow		
Notes/Com	nents:					