Date Received: ____________  Occurrence Date: __________  Occurrence Time: ____________

Participant Name(s): _______________________________  Med. Record Number: _______________

Person Submitting Grievance: ______________________  Staff Completing Report: _______________________________

Relation to Participant (circle one): Caregiver, Contracted Provider, Family, or Participant, PACE Organization

How Reported:  In Person [ ]  By Phone [ ]  By Mail [ ]  E-Mail [ ]

Home Care Services [ ] YES  [ ] NO

Description of Grievance:

Reason for Grievance

Activities
☐Activities are Not Age or Ability Appropriate
☐Dissatisfied with Frequency of Activities
☐Dissatisfied with Quantity of Activities
☐Dissatisfied with Variety or Type of Activities
☐Requesting Activities Outside of Center (Trips)
☐Requesting more Activities for Men
☐Other

Communication
☐Call(s) not returned
☐Language Translation not available
☐Communication is Unclear
☐Difficulty contacting On-Call
☐Difficulty Contacting PACE Center during center hours
☐Not informed of Appointment(s) outside of PACE Center
☐Not informed of Appointment, in timely manner
☐Not informed of changes in the Participant’s Condition
☐Not Informed of Changes to Home Care Schedule
☐Not informed of Changes to Medication
☐Not informed of Changes to Scheduled Appointment(s)
☐Rude Behavior/Communication
☐Staff is inattentive
☐Other

Contracted Specialist
☐Dissatisfied with Care Provided
☐Dissatisfied with how Toenails were cut
☐Length of Time to receive dentures
☐Length of Time to Receive Glasses
☐Length of time to schedule an appointment
☐Records were not sent to specialist prior to appointment
☐Excessive Provider Office Wait Time
☐Specialist appointment was not made
☐Other

Contracted Facility (Hospital, SNF etc.)
☐Availability of staff to provide assistance
☐Cleanliness of facility
☐Did not provide for Participant ADLs
☐Missing Clothes or Personal Items
☐Participant Left in Bed too long
☐Quality of Care at the Facility
☐Report of Abuse
☐Staffing
☐Other

Dietary
☐All participants at table are not served at the same time
☐Dissatisfied with alternate selections
☐Dissatisfied with physician prescribed diet
☐Dissatisfied with selection or variety of foods (include snacks, ethnic foods etc.)
☐Dissatisfied with sugar-free food items
☐Food temp-too cold
☐Food temp-too hot
☐Foreign Object
☐Not allowed to bring food from home
☐Not allowed to use salt or pepper
☐Not enough assistance from staff during meals
☐Quality of food
☐Staff hand washing/infection control
☐Wait time for food service too long
☐Other

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Reason for Grievance (cont’d)

Disenrollment
☐ Dissatisfied with how Care was Coordinated with New Provider(s)
☐ New Provider did not Receive Medical Records from the PACE Organization
☐ Other

Enrollment
☐ Dissatisfied with Cost
☐ Not Aware of the Need to Utilize the PACE Organization’s Provider Network
☐ Unaware of Participant liability
☐ Other

Home Care
☐ Dissatisfied with Staff Behavior (rude behavior)
☒ Dissatisfied with Staff Member Assigned to Perform Home Care
☐ Missed Appointment
☐ Report of Abuse
☐ Report of Missing Items
☐ Requesting a Decrease in Home Care
☐ Requesting Additional Home Care
☐ Staff does not have enough time to complete tasks
☐ Staff Early for Appointment
☐ Staff Late for Appointment
☐ Staff not aware of tasks to be completed
☐ Staff unable to enter home/access lock box
☐ Tasks were not completed
☐ Unable to hear or understand staff member

☐ Dissatisfaction with Quality of Home Care
☐ HHA late/absent on Scheduled Day of Service
☐ Dissatisfaction with Quality of Day Care
☐ Other

Marketing
☐ PACE Organization Misrepresented Available Services
☐ PACE Organizations Marketing is Misleading
☐ Other

Medical Care
☒ Activity Interrupted to Complete Clinic Visit
☒ Activity Interrupted to Complete Therapy
☒ Disagreement with Diagnosis or Treatment
☐ Dissatisfied with Frequency of Clinic Visits/Too Few
☒ Dissatisfied with Wait Time in the Clinic
☒ Insufficient Privacy in the Clinic
☒ Insufficient Privacy when Receiving Personal Care
☒ Insufficient Staff in Clinic
☒ Insufficient Staff in PT/OT Area
☒ Medical Care and Specialist Rude/Abusive
☒ OT/PT Area is too small
☐ Pain is not addressed by the Clinical Staff
☐ Personal Care is rushed
☐ Physician does not listen to participant concerns
☐ Other

Medication
☒ Disagreement with Medication Regime
☐ Medication Error
☐ Medication Missing
☐ Medication is not administered in a private setting
☐ Medication is not available
☐ Medication was discontinued
☐ Medication was not delivered to home
☐ Requested Medication was not provided
☐ Other

PACE Services
☒ Dissatisfied with Ability to Obtain Routine Dental Care
☒ Dissatisfied with Ability to Obtain Routine Hearing Services
☒ Dissatisfied with Ability to Obtain Routine Vision Care
☒ Dissatisfied with Availability of Specialist Services
☒ Dissatisfied with Center attendance-Too few days
☒ Dissatisfied with Center attendance-Too many days
☐ Quality of other covered services

☐ Dissatisfied with Provider Network-Homecare Providers
☒ Dissatisfied with Provider Network-Hospitals
☒ Dissatisfied with Provider Network-Nursing Facilities
☒ Dissatisfied with Provider Network-Specialists
☒ Dissatisfied with Member Svcs & Plan Operations
☒ Misinformed re: plan benefits/rules
☒ Dissatisfied with Care Management
☒ Violation of Member Rights
☒ Plan Staff Rude or Abusive
☒ Denial of Expedited Appeal
☒ Hearing/Vision Needs not accommodated
☐ Wait too long to get appointment or service
☐ Other

Supplies
☐ Dissatisfied with Quality of Supplies
☐ Insufficient Quantity of Supplies
☐ Participant Privacy Issue
☐ Supplies were not delivered to Home
☐ Other

Transportation
☐ Arrives too early
☐ Cannot take wheelchair on van
☐ Complaint of discomfort
☐ Condition of the vehicle
☒ Dissatisfied with drivers speed or driving
☐ Late pickup
☒ Length of ride too long
☐ Missed pick-up
☐ Not aware of change in pick up time
☐ Not enough room on van when supplies are being delivered
☐ Other participants’ behavior on the van
☐ Participant arrived at home in soiled clothing
☒ Quality of Transportation
☐ Temperature on van is too hot/cold
☐ Van crowded
☐ Other

☐ Quality of other covered services

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Actions taken:
☐ Added Additional Activities
☐ Added Additional Contracted Facilities
☐ Added Additional Contracted Specialists
☐ Added Additional Equipment
☐ Added Additional Menu Items
☐ Added Additional Staff
☐ Added Additional Transportation
☐ Changed Staff that Provides Care
☐ Conducted Contractor Oversight
☐ Conducted Quality Oversight at PACE Center
☐ Counseled Staff
☐ Dietary Assessment
☐ Equipment was Serviced or Replaced
☐ Home Care Assessment

☐ Implemented a New Policy
☐ Increased Home Care Hours
☐ Instituted Quality Improvement Measures
☐ Met with Contracted Provider to Review Grievance
☐ Modified the PACE Center Environment
☐ Obtained Opinion from a Specialist
☐ OT Assessment
☐ Participant or Caregivers
☐ Reeducated on Policies/Procedures
☐ PCP Assessment
☐ Provided Participant Education
☐ Provided Staff Education/Training
☐ PT Assessment
☐ Revised Activity Schedule
☐ Revised Existing Policy
☐ Revised Marketing Material

☐ Revised process for communicating with contracted facility
☐ Revised process for communicating with contracted specialist
☐ Revised process for medication delivery
☐ Revised process for scheduling clinic visits
☐ Revised process for scheduling transportation
☐ Revised provider contract
☐ Revised the participant’s Plan of Care
☐ RN Assessment
☐ Staff placed on performance improvement plan
☐ Staff reeducated on policies/procedures
☐ SW Assessment
☐ Transportation Assessment

Immediate (same business day) resolution?      ☐ Yes  ☐ No
Standard Resolution      ☐ Yes  ☐ No
Substantiated      ☐ Yes  ☐ No
Resolved to Participant Satisfaction      ☐ Yes  ☐ No
Alternative Solution      ☐ Yes  ☐ No

Resolution:________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Date Resolved: _____________________

Date of Oral Notification of Resolution for same day grievance resolution: ______________________

Participant Received Grievance Fact Sheet      ☐ Yes  ☐ No Date: _____________________

For Office Use Only:
Participant received written notification of receipt of grievance      ☐ Yes  ☐ No  ☐ NA Date: _____________________
Participant received written notification of resolution      ☐ Yes  ☐ No  ☐ NA Date: _____________________

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