THE CARE TEAM
Home Health Care

SERVICE COMPLAINT FORM

Patient Name: _____ Date of Birth: _____
Last First

Date of Incident: _____Date Reported: _____ Time Reported: _____Am/PM

Name of Person Initiating Compliant: _____

Relationship to Patient: _____

Phone # for follow up: _____

Nature of Complaint:

❑ Care Related ❑ Medication Issue ❑ Staff Behavior ❑ Staff Communication ❑ Scheduling Issue

❑ Policy Issue ❑ Billing/Collections ❑ Referral ❑ Other: _____

Complaint Specifics (Briefly describe complaint, provide dates, times, location and persons involved; if complaint is written, attach copy and other supporting documentation; (use additional paper if necessary):

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Expected Outcome:

What are your views and expectations? _____

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Who has been involved and how? _____

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FOR TCT STAFF ONLY

Action Taken/Resolution (use additional paper if necessary)**:** _____

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✶Initial Contact With: _____ ❑ Patient ❑ Legal Representative

Date: _____ Time: _____

Action Taken By: _____ Date: _____

Clinical Manager/Designee Signature: _____ Date: _____

✶Resolution Contact With: _____ ❑ Patient ❑Legal Representative

By: ❑ Telephone ❑ Email ❑ Letter ❑ Other: _____ Date: _____ Time: _____

Patient Satisfied: ❑ Yes ❑ No Patient/Family notified of right to appeal if unsatisfied? ❑ Yes ❑ No
Number of days from initial complaint to resolution: _____