

PURPOSE: Our program has an obligation to protect and promote your rights as a consumer of healthcare services. This includes providing you with a timely and efficient way of handling any concerns or complaints you might have about the services we offer. Please be assured, we value and appreciate your concerns as we believe they help to make us better. No one in this agency will retaliate against you for filing a grievance. The care we offer you will continue to meet all standards of care. All we ask is that you follow the process we have outlined below so we may address your concerns in a timely and organized.

PROCEDURE(S): Before you file a formal grievance, we encourage you to first, try and resolve the problem with the person or people you believed caused the problem. If this is not possible, or the answer you receive is not acceptable to you, we ask that you complete and submit the attached form. You can present the completed form to the staff member who is the subject of your complaint or to one of the front office staff. **The grievance should be submitted within 48 hours to 5 days of the incident.**

Whoever accepts your form will write a note in your chart indicating the date and time the grievance was submitted. The staff person receiving the grievance will then bring it to the attention of the Quality Assurance Manager within 24 hours after it was received.

The Quality Improvement/Performance Manager will either investigate the grievance or delegate the responsibility for the investigation depending upon the nature of the complaint. You will be contacted about the investigation and possible solutions to the problem within 72 hours after the grievance was received, unless the grievance was filed anonymously.

To mail in a grievance, please return completed form to:

Quality Improvement/Performance Manager
Community Outreach Medical Center (COMC)
1090 E. Desert Inn Rd., Suite 200
Las Vegas, NV 89109
(702) 657-3873

Patient Name: _____ Date: _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Please check this box if you would like to remain anonymous.

(By checking this box, we are unable to follow-up with you in regards to results or resolutions)

Summarize the nature of the grievance (specify the basis of the grievance, including all contract violations, policies, practices and/or laws):

Time of Incident: _____:_____ AM / PM Date of Incident _____ / _____ / _____

Name of staff member(s) involved: _____

Desired remedy (as a result of your grievance, what would you like to see happen?)

Patient Signature: _____ Date: _____

Office Use Only:

Grievance Received _____ / _____ / _____

Grievance Investigated _____ / _____ / _____

Grievance Resolved _____ / _____ / _____

Follow-up Completed _____ / _____ / _____

QAM Signature: _____ Date: _____