Community Outreach MEDICAL CENTER
BRINGING COMMUNITY AND HEALTHCARE TOGETHER

Patient Grievance Policy & Form

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 Assurance 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 by the Quality Assurance Manager, unless the grievance was filed anonymously.

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

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

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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)

Please indicate the program in which you are filing the grievance against:
☐ Community Outreach Medical Center (Physical Health)
☐ Certified Community Behavioral Health Center (Behavioral Health)

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

_____

_____

_____

_____

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

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*: _____