CalOptima Health
A Public Agency
13300 Garden Grove Blvd.
Garden Grove, CA 92843
☎ 714-468-1100
TTY: 714-468-1063
caloptima.org

GRIEVANCE REPORT

Center: CalOptima Health PACE	***Participant's name:*** _____

(1) Individual filing the grievance:	***(2) Name and Contact Information:*** (if other than Participant or Staff)
☐ Participant ***(not required)***	*(Name/Relationship to Participant)*
☐ PACE staff on behalf of participant	*(Address)*
☐ Family Member (please complete (2)	*(Telephone)*
☐ *Participant's representative (please complete (2)*	

Please provide a complete description about your grievance:
What happened? Who was involved? What date did the event occur? Where did the event occur? If you need more space, please attach additional pages. Check box if additional pages are attached ☐

Signature of Person Reporting the Grievance:_____ Date: _____

Please note: Participants are not required to sign this form

I have been advised of my right to ask for help in filing my grievance. I have received written information about the grievance process._____ (please initial if correct).
I have designated the above person to act as my representative and to assist me in this grievance process._____ (if applicable, participant initials).

If applicable, please indicate the CalOptima Health PACE staff assisting to complete this form:

*Name/Job Title/Phone Extension:*_____

When completed, please return this report and any additional pages to the Center Manager OR mail to:

EMAIL:

pacequality@caloptima.org

PHYSICAL MAIL:

CalOptima Health PACE
Attn: QI Department
13300 Garden Grove Blvd.
Garden Grove, CA 92843

Date Report Received: _____

For Internal Staff Use Only:

Quality Improvement Department notified of the grievance by telephone or e-mail: Date_____

☐ Report received by the QI Department: Date _____

☐ PACE Staff Documented Receipt of Grievance into Grievance Log: Date: _____

☐ QI Staff telephoned acknowledgement of receipt to Participant (within 5 days): Date: _____ Time: _____

☐ QI Staff sent a written acknowledgment to participant (within 5 days): Date Sent: _____

☐ PACE Medical Director is notified of the grievance concerning medical care or urgent grievance: Date**:** _____

☐ Manager/Supervisor responsible for services or operations is notified of the grievance. Date: _____

Thirty calendar days from the day the grievance was received, either:

☐ The grievance has been resolved. The PACE Medical Director or QI staff has sent the Participant a report describing the problem's resolution, the basis for the resolution, and the review process if dissatisfaction continues. Date Sent:_____ OR

☐ The grievance is pending. The QI staff sent a report with a brief explanation of the reasons for the delay to the Participant and/or his/her representative. Date Sent: _____

Expedited Review: If the grievance involves an imminent and serious threat to the health of the participant

☐ The participant and/or representative are immediately notified by telephone of the receipt of the request for an expedited review. Date: _____ Time: _____

☐ The participant and/or representative are notified of their right to notify CMS and DHCS of the grievance.

☐ No later than 3 days from receipt of the grievance, a written statement of the final disposition or pending status of the grievance is sent to the Participant and/or representative, CMS and DHCS.

Comments: