

Grievance Report Form

Participant Name (Last Name, First):	
Date:	Member ID:
Individual filing the grievance:	Contact Information:
Participant	(complete only if non-participant):
☐ IIH staff on behalf of participant	Name:
Contracted Provider	Tvanic.
☐ Participant's Representative* ☐ Other*	Relationship:
*fill out contact information	•
fitt out contact information	Phone:
Name/Job Title of IIH Staff receiving the grievance:	一
	Address: *Electronically available upon request
	Electronically available upon request
Department:	
ype of Grievance (Choose all that apply)	
☐ Activities ☐ Enro	1
☐ Communication ☐ Hom	
☐ Contracted Facility ☐ Mark	
1	ical Care
☐ Dietary ☐ Med	
☐ PACE Services ☐ Supp	blies
lease provide a complete description about yo	ur grievance below.
Pate(s) Occurred:	
ocation(s) Occurred:	
H Staff Involved:	
Description of Events (Continued on next page if no	ecessary):
Check here if you have used additional pages at	nd they are attached.
	y additional pages to Quality Improvement (QI)

Review Date: 9/30/2021



Description of Events (Continued if applicable):		

Review Date: 9/30/2021