North Alabama CommunityCare

GRIEVANCE PROCESSING FORM

If you are unhappy with your services, you have the right to file a complaint or grievance. The care you receive is important to us. Every effort will be made to resolve your complaint or problem. The grievance process is in place to address complaints regarding, but not limited to dissatisfaction with your NACC case manager or other NACC staff members, complaints related to PCPs/MCPs or their staff members, or denial of Care Management services. You may file a grievance through any care provider, program staff member, or by contacting the Alabama Medicaid Agency. All such grievances and complaints are to be treated on a strictly confidential basis and are addressed in a timely manner.

If you need assistance filling out this form, your Care Manager or other NACC staff member can assist you. Please answer all questions in Section I to the best of your ability.

Section I – Recipient (to be filled out by Recipient or Recipient's representative)

Recipient Name: _____ Medicaid Number: _____

Full Address: _____

Phone: _____ Email: _____

Person filing grievance (if other than Recipient): _____

Relationship to Recipient: _____

Full Address: _____

Phone: _____ Email: _____

Person(s) grievance is being filed against:

Name: _____ Phone: _____

Organization Name: _____

Address: _____

Date(s) incidence occurred: _____

Statement of incidence, problem, or complaint (attach additional page(s) if needed)

_____

_____

_____

_____

_____

_____

_____

_____

Are you requesting a new Care Manager and/or Provider? ☐ No ☐ Yes, Provider ☐ Yes, Care Manager

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Requested resolution or desired outcome (attach additional page(s) if needed)

Recipient or representative signature: _____ Date: _____

Section II – North Alabama Community Care (to be filled out by NACC staff)

Action taken and resolution (attach additional page(s) if needed)

Date grievance received: _____ **Date grievance resolved:** _____

Recipient's request was: ☐ Approved ☐ Denied ☐ Not applicable. Filing grievance only.

If denied, please explain: _____

If new provider and/or care manager is assigned, list below:

Current Provider: _____ Current Care Manager: _____

New Provider: _____ Next appointment date: _____

Provider Address: _____ Provider Phone: _____

New Care Manager: _____ Phone: _____

Grievance completed by: _____

Title: _____ Date: _____

Grievance reviewed by: _____

Title: _____ Date: _____