SOUTHWEST PIEDMONT HIV CARE CONSORTIUM GRIEVANCE FORM

Client Name:____

Client Mailing Address:____

Client Phone Number:__________________________

Date(s) Incident Occurred:____

Name of Service Provider:____

Brief Summary of Incident/Complaint: Please tell us what occurred, when it happened and who it involved. If the grievance involves a denial of services, include the service requested, cost of service, and medical necessity of service (you may summarize on a separate piece of paper and attach, also feel free to attach and include any document that may support your complaint).

1. Have you reviewed the S/PHCC grievance policy and procedures? Yes No
2. Have you discussed this issue with the provider(s) involved? Yes No
3. Was there a satisfactory resolution proposed? Yes No
4. Do you wish to contact and discuss this issue confidentially with a client representative not associated with your service provider? Yes No

In accordance with the grievance procedure adopted by the Southwest/Piedmont HIV Care Consortium and my Service Provider, I am submitting this grievance to the Council of Community Services as lead agent of the Consortium. I hereby authorize a representative of the lead agency to contact the provider listed above and discuss my complaint.

____________________ ____

Date Signature of Client filing this Complaint

Mail original to: Council of Community Services, c/o Robert Morrow, Director of Care Services, P.O. Box 598, Roanoke, VA 24004-0598. Mark both sides of the envelope confidential.