CENTRAL VALLEY INDIAN HEALTH, INC.
2740 HERNDON AVENUE
CLOVIS, CA 93611
(559) 299-2578

CENTRAL VALLEY INDIAN HEALTH, INC.

POLICIES AND PROCEDURES MANUAL

PATIENT GRIEVANCE POLICY

CENTRAL VALLEY INDIAN HEALTH, INC.

GRIEVANCE POLICY

RECORD OF CHANGES

NUMBER	CH / REV	DATE	ENTERED BY
0	IMPLEMENTATION	1993	C.D.FOWLER
1	REVISION	JAN 1998	J.DIAZ
2	CHANGE	OCT 2003	Clinic Coordinator
3	Change	August 25, 2006	Clinic Coordinator
4	CHANGE	November 2009	Administrative Asst.
5	Change	November 2013	Chief Operating Officer

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PATIENT GRIEVANCE POLICY

1. Purpose: To provide a method and procedure for patients to submit formal complaints and/or to resolve patient related problems within Central Valley Indian Health, Inc.

2. Policy: Formal patient complaints occurring within Central Valley Indian Health, Inc. will be treated as a patient grievance and will be handled promptly. Staff personnel receiving formal grievances are to forward them to the appropriate Staff Director who will review and attempt to resolve each problem. In the event the Staff Director is unable to resolve the problem, the complaint or grievance shall be forwarded to Administration who will attempt to resolve the problem.

   A. All patient grievances will be forwarded to the Quality Assurance Committee along with an explanation of the measures taken to resolve the grievance.
   B. Patient grievances may be presented in person, by phone call, or in writing. A form for formal grievances is attached and recommended for use for those desiring to file formal grievances.
   C. Patients that identify themselves as Managed Care patients with either Blue Cross or Health Net, shall also have their grievances and the resolution not be reached for any reason, the managed care plan administrator shall be requested to provide assistance in resolving the grievance.

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GRIEVANCE FORM

This form is to be used by patients to file formal grievances at Central Valley Indian Health, Inc.

Patients Name ______________________

Clinic or CVIH site where grievance occurred ______________________

Date grievance filed ______________________

Date grievance occurred ______________________

Are you a Medi-Cal Managed Care Patient? ________Yes ___________No

If so, which plan are you with? ________ Blue Cross _________ Health Net

Please describe the grievance you are submitting. Include as many facts as possible.

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Signature of patient filing grievance: ______________________________________

(*If additional space is needed, attach another sheet or write on the back of this form)*