Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

HRSA Incident / Complaint Form

(To be completed by the HRSA employee taking the complaint) ☐ Incident ☐ Complaint ☐ Both

1. DATE RECEIVED	TIME RECEIVED	2. RECEIVED BY (HRSA EMPLOYEE)	TELEPHONE NUMBER

3. Date of alleged incident or action which resulted in complaint:

4. Method of Contact: _____ (e.g. phone call, letter, fax, e-mail)

Does the customer/complainant request anonymity? ☐ Yes ☐ No

(NOTE: If you do not want your identity disclosed, we will endeavor to delete identifying information about you from information provided to the facility and/or under public records requests to the extent allowed by law.

5. Information about the incident/complainant:

(NOTE: We request this information in order to permit us to acquire more information from you if necessary.)

NAME	ADDRESS

PHONE NUMBER(S) HOME	WORK	CELL	OTHER

6. Does the customer/complainant want to be contacted about the outcome of HRSA activity on this issue? ☐ Yes ☐ No

7. What is the customer/complainant's relationship to the subject of the complaint? (e.g. patient, parent, employee, friend, other)

Is the customer/complainant on Medicaid? ☐ Yes ☐ No

8. If you have this information, please tell us what the complaint is about:

- ☐ A HRSA licensed or certified agency
- ☐ A HRSA provider or health care practitioner
- ☐ A HRSA health plan (such as a Medical Care Organization or Pre-paid Inpatient Health Plan
- ☐ Other: _____

9. THE PROVIDER AGENCY'S NAME	10. THE PROVIDER OR PRACTITIONER'S NAME	11. THE DSHS OR RSN REGION

12. Information about the complaint: Describe who was involved. What happened? When did it happen? Where did it happen? Why did it happen? How did it happen? Have any actions been taken in response to the incident/complaint in an attempt to resolve the issue? Is there a need for assistance or additional services to be provided to patients impacted by the incident/complaint?

(use additional pages as necessary)

13. Does the report involve (please check all that apply):

☐ Abuse or neglect of a child or vulnerable adult	☐ Concern about treatment methods	☐ Ethical concerns
☐ Confidentiality	☐ Staff qualifications or numbers	☐ Patient / Child death, death of a child or adult requiring a CPS/APS referral
☐ Financial issues	☐ Patient health or safety issues (describe)	☐ Discrimination (describe)
☐ Patient Rights, Americans with Disabilities Act (ADA) (describe)	☐ An incident requiring a time-sensitive notice to a supervisor	☐ A HIPAA violation requiring referral to Office of Civil Rights or DSHS Privacy Officer
☐ Other (describe):		

The following information is to be completed by the HRSA Division Incident/Complaint Manager (Please check all that apply)

RESOLUTION:

Complainant was referred to:	More information is needed from:	Investigation is:
☐ Agency grievance process ☐ DOH Professional licensing and certification team. ☐ Insurance Commissioner ☐ Police/prosecutor's Office ☐ U.S. Attorney (42 CFR) ☐ Regional administrator ☐ RSN/PIHP administrator ☐ Other	☐ Complainant ☐ Subject ☐ On-site investigator (assigned to _____) ☐ Licensing and certification team ☐ Other	☐ Completed ☐ Allegations are not confirmed ☐ Some or all allegations are confirmed.

☐ Incident/Complaint: _____ Entered into database on: _____

(Number Assigned by Division Incident/Complaint Manager)

☐ Copies of this document are being sent to:

☐ Incident/Complaint is forwarded to HRSA Division Incident and Complaint Manager