Section I. Complaint Information Intake *(Please complete this Section for **all** types of complaints)*

Type of Complaint : ☐ Access and Availability ☐ Quality of Care ☐ Quality of Service ☐ Administrative		
Person Receiving the Complaint:	Date Complaint Received:	Complaint Received via: Select One
Access and Availability Reason Code: Select One	Quality of Service Reason Code: Select One	Quality of Care Reason Code: Select One
Administrative Reason Code: Select One	Urgent Complaint? ☐ Yes ☐ No	
COMPLAINANT/PATIENT INFORMATION		
Complainant Name *(This may be different from the patent):*	File ID:	
Patient Name:	Patient ID:	
Address:		
Home Telephone:	State: NY	Zip Code:
Mobile Number:	Work Telephone:	
Previous Complaint History? ☒ Yes ☐ No If Yes, please summarize briefly here:		
PROVIDER INFORMATION		
Last Name:	First Name:	
STAFF INFORMATION		
Last Name:	First Name:	
DESCRIPTION OF COMPLAINT		
Provide a brief summary of the complaint:		
Administrative Complaints Only:		
Provide a summary of the Complaint Resolution for Administrative Complaints:		
Date Administrative Complaint Closed:		
Quality Complaints Only:		
Date Referred to Quality Management for Investigation *(all access and availability, quality of care and quality of service complaints are referred to QM for processing)*:		

Following Sections to Be Completed by Quality Management

Section II. Patient/Complainant Communication/Response

Date Complaint Received in QM:
Acknowledgement Letter Sent? ☐ Yes ☐ No ☐ N/A Date Letter Sent.
Verbal Contact with patient or complainant after initial complaint received? ☐ Yes ☐ No Date of Contact: Please provide a brief summary of Complaint Conversation:

Section III. Provider Communication/Response

Does the Provider have a Previous Complaint History? ☐ Yes ☐ No If Yes, please summarize briefly
Provider Response Requested? ☐ Yes ☐ No Date Requested:
Response Received? ☐ Yes ☐ No Date Received:
Provide a brief summary of response:

Section IV. Staff Communication/Response

Does the Involved Staff have a Previous Complaint History? ☐ Yes ☐ No If Yes, please summarize briefly
Staff Response Requested? ☐ Yes ☐ No Date Requested:
Response Received? ☐ Yes ☐ No Date Received:
Provide a brief summary of response:

Section V. Quality Management Review Findings

Review Summary:	
Forward to Medical Director? ☐ Yes ☐ No Date Forwarded:	
QM Manager Signature:	Date:

Section VI. Medical Director Review

Date of Review:	Provider Involved in Review? ☐ Yes ☐ No ☐ N/A
Comments/Recommendations:	
Medical Dir. Signature:	Date:

Section VII. Severity Level/Actions

Please select the appropriate severity level and all recommended actions within the selected level that apply.		
Severity Level	**Action(s)**	**Date Completed**
☐ **0 No Confirmed Quality Concern**	☐ Track and Trend	
	☐ Provider Education	
	☐ Staff Education	
	☐ Patient Education	
	☐ Other: (*please specify*)	
☐ **1 Minor Quality Concern**	☐ Track and Trend	
Refer to Section VIII for CAP Monitoring	☐ Provider Education	
	☐ Request written Corrective Action	
	☐ Staff Education	
	☐ Other: *(please specify)*	
☐ **2 Moderate Quality Concern**	☐ Track and Trend	
Refer to Section VIII for CAP Monitoring	☐ Provider Education	
	☐ Request written Corrective Action	
	☐ Staff Education	
	☐ Peer Review	
	☐ To Provider File	
	☐ Peer Review	
	☐ To Staff File	
	☐ Other: *(please specify)*	
☐ **3 Significant Quality Concern**	☐ Track and Trend	
Refer to Section VIII for CAP Monitoring	☐ Provider Education	
	☐ Request written Corrective Action	
	☐ Staff Education	
	☐ Peer Review	
	☐ NPDB notification	
	☐ To Provider File	
	☐ To Staff File	
	☐ Terminate Provider	
	☐ Terminate Staff	
	☐ Other: *(please specify)*	

Section VIII. Corrective Action Plans

Corrective Action Plan Requested from:	☐ Provider ☐ Staff ☐ Both	
Complete below when CAP requested from Provider		
Date CAP due:	Date Due:	
Corrective Action Received within specified time frame? ☐ Yes ☐ No	Date Received:	
If No, Date Medical Director Notified :	CAP sent to Medical Director for approval? ☐ Yes ☐ No	
CAP follow-up dates: *(Please document dates for QM follow-up to monitor CAP progress. **Note**: Not all CAPs will require 4 follow-up dates.)*	Follow-Up Date 1: Follow-Up Date 2: Follow-Up Date 3: Follow-Up Date 4:	
CAP Completed? ☐ Yes ☐ No	Date Completed:	
If CAP Not Completed, Please specify reason.		
Complete below when CAP requested from Staff:		
Date CAP due:	Date Due:	
Corrective Action Received within specified time frame? ☐ Yes ☐ No	Date Received:	
If No, Date Medical Director Notified :	CAP sent to Medical Director for approval? ☐ Yes ☐ No	
CAP follow-up dates: *(Please document dates for QM follow-up to monitor CAP progress. **Note**: Not all CAPs will require 4 follow-up dates.)*	Follow-Up Date 1: Follow-Up Date 2: Follow-Up Date 3: Follow-Up Date 4:	
CAP Completed? ☐ Yes ☐ No	Date Completed:	
If CAP Not Completed, Please specify reason.		

Date Case Closed: