



1333 Bush Street
San Francisco, CA 94109
415/292-8888
TTY: 711

GRIEVANCE REPORT
(NOT part of the participant's medical record)

Participant's Name: _____ **On Lok PACE #:** _____ **Center/Team:** _____
Last First

Date grievance received by On Lok PACE: _____

Name of person assisting participant with the filing of this grievance: _____

- Participant's representative
- On Lok PACE staff member
- California Department of Managed Health Care (DMHC) Help Center

If participant's representative is selected, please indicate relationship to participant: _____

Please provide a complete description of the grievance. (Include the date of the event, the location of the event, the person(s) involved, any steps taken to resolve the grievance, and direct quotes when possible). If you need more space, please attach additional pages.

Signature of person reporting the grievance: _____ Date: _____

- If you believe you have been subjected to discrimination, please indicate below the basis on which you believe these discriminatory actions were taken (check all that apply):
 Race Color National Origin Other (please specify): _____
- Participant has been informed of his/her right to request assistance in completing the Grievance Report from the California Department of Managed Health Care and received written information on the grievance process. Assistance can be obtained by contacting the California Department of Managed Health Care at 1-888-466-2219.

As soon as the report is completed, please forward the report and any additional pages to the Health Plan Services Department at the Gee Center of On Lok PACE.

IMPORTANT: If you need help with this form, require language assistance, or prefer to file a grievance by telephone, please call our Health Plan Services Department at 415-292-8895 or toll-free at 1-888-996-6565 (TTY: 711). Help is available from 8:30 a.m. to 5:00 p.m., Monday through Friday. You may also access our website at www.onlok.org/PACE to file a grievance or receive information about our grievance process.

California Department of Managed Health Care Complaint Process

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **415-292-8895** or **1-888-996-6565** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website <http://www.dmhc.ca.gov> has complaint forms, IMR application forms and instructions online.

For On Lok PACE Staff Use Only:

On Lok PACE staff member who received the grievance: ___ Health Plan Services Dept. ___ Social Worker ___ Other

- Report received by the On Lok PACE staff member identified above: Date _____
- Health Plan Services Department notified of the grievance by telephone or e-mail: Date _____
- Health Plan Services Department telephoned acknowledgment of receipt to the participant (within 5 calendar days): Date _____ Time _____
- Health Plan Services Department sent a written acknowledgment to the participant (within 5 calendar days): Date _____
- Chief Medical Officer is notified of the grievance concerning medical care or urgent grievance: Date _____ Time _____
- Contract Manager for the Department of Health Care Services (DHCS) is notified of the grievance: Date _____ Time _____

Thirty calendar days from the day that the grievance was received, either:

- The grievance has been resolved. The Chief Medical Officer or the Senior Director of Health Plan Services has sent a report describing the problem's resolution, the basis for the resolution, and the review process if dissatisfaction continues to the participant and/or the participant's representative. *OR*
- The grievance is pending. A report with a brief explanation of the reasons for the delay has been sent to the participant and/or the participant's representative and the Contract Manager for the DHCS.

Expedited Review: Grievance involves an imminent and serious threat to the health of the participant

- The participant and/or the participant's representative are immediately notified by telephone of the receipt of the request for an expedited review.
- The participant and/or the participant's representative are notified of their right to notify the DHCS, the DMHC, and the Department of Social Services of the grievance.
- No later than 3 days from receipt of the grievance, a written statement of the final disposition or pending status of the grievance is sent to the participant and/or the participant's representative, the DHCS, and the DMHC.