Immaculate Home Health Care

Your Care, Our Responsibility

COMPLAINT REPORT FORM

Complete this form if you have concerns about the health care or treatment that you or a family member received or did not receive. Answer all questions. Give complete details. Use additional sheet, if necessary. You may use this form as a guide when making a complaint by telephone. We will investigate your concerns based on the information that you provide.

You may file an anonymous complaint

Complete the following questions.

I. Name of patient/resident/client involved in the incident: _____

Sex: [] Male [] Female **Age:** _____

II. Health care facility, residence, or community treatment program involved in the incident:

Name: _____

Address: _____

Check the type of facility or program: [] Nursing home [] Adult medical day care [] Assisted living [] Hospital [] Home health agency [] Residential treatment center [] Community mental health program [] Hospice [] Dialysis Center [] HMO [] Ambulatory surgery center [] Residential services agency [] Birthing center [] Medical laboratory [] Community drug treatment program [] Developmental disabilities provider [] Other. Please specify _____

III. Witnesses to the incident:

Name	**Contact information, if known** (include telephone number)
_____	_____
_____	_____
_____	_____

IV. Person filing complaint or reporting incident (optional). Note: If you would like a deficiency report that may result from our investigation, please complete this section.

Name: _____ **Relationship:** _____

Address: _____

Telephone: _____

May we reveal your identity during the investigation of your complaint? [] Yes [] No

V. Briefly describe the incident or your concerns (use additional paper if necessary):
Include dates and times, persons involved, and description of what happened. Include attachments, if appropriate. **Note:** If this is an anonymous report, be complete since we will not be able to contact you to obtain missing information.

VI. Have you reported this incident or concern to the person in charge of the facility, residence or program? [] Yes [] No

Address written complaints to the appropriate licensing unit (listed below) and mail to:

Immaculate Home Health Care
7230 New Falls Rd
Levittown, PA 19055