HSAG HEALTH SERVICES ADVISORY GROUP
ESRD Network 15

Patient Grievance Form

To request assistance in resolving a concern with your dialysis provider, please complete the below forms and return to the Network.

HSAG: ESRD Network 15
3025 South Parker Road, Suite 820 | Aurora, CO 80014
800.783.8818 (phone) | 303.860.8392 (fax)

Patient Information

Name:_____ Date of Birth:_____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

If you do not have a phone, may we leave a message for you at your facility? ☐ Yes ☐ No

Facility Associated with this Grievance

Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____

Please check (✓) one:

☐ I have approached the facility with this grievance and am not satisfied with the outcome or handling of my concern. I am not satisfied because:

☐ I have NOT approached the facility with this grievance because:

Please check (✓) one:

☐ I choose to represent myself during this grievance process.

☐ I have chosen a representative to help me during this grievance process. *(Complete and submit attached representative authorization form.)*

Please check (✓) one:

☐ I will complete the *Content to Disclose Your Identity* form to allow the Network to release my identity to the appropriate individuals in the course of processing this grievance.

☐ I choose to remain anonymous. I understand that remaining anonymous may result in the inability to fully process my grievance. If this occurs, the Network will notify me.

Grievance

- *Please describe your concern with as much detail as possible.*
- *Please list dates and approximate times when the incident occurred.*

Signatures

Patient

_____ *Date:*_____

Authorized Patient Representative *(if applicable)*

_____ *Date:*_____

Consent to Disclose Patient Identity

HSAG: ESRD Network 15 will not reveal your name to any facility or healthcare professional named in your grievance without your consent. If you do not give permission to Network 15 to use your name, we will handle your concern as an anonymous grievance. An anonymous grievance may be more difficult to investigate, which may prevent your concerns from being fully addressed.

Please indicate either YES or NO and return this signed document to:

Justin Carr, Patient Services Manager
HSAG: ESRD Network 15
3025 South Parker Road, Suite 820
Aurora, CO 80014

☐ YES, I give permission to Network 15 to reveal my identity.

☐ NO, I do NOT want my identity to be revealed.

Patient Name *(please print)*

_____ Date:_____

Signature

_____

It is important for you to know that it is unlawful for a facility or its staff to retaliate against a patient or another individual for filing a grievance. If at any time you feel that you are being discriminated against or treated unfairly, please contact Network 15 or the Department of Health Services immediately.

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3025 South Parker Road, Suite 820
Aurora, CO 80014
800.783.8818 (toll-free phone) 303.860.8392 (fax)

Please see the enclosed document for Department of Health Services District

Offices.

Representative Authorization Form

Appointment of Representative

I, _____, designate _____
(Patient Name) *(Name of Representative)*

to represent me in filing a grievance related to my dialysis or kidney transplant care.

I understand that by signing this form, I give permission for personal medical information related to my grievance to be disclosed to my representative.

I understand that once I designate this person as my representative, he or she will communicate with HSAG: ESRD Network 15 and will act on my behalf with regard to my grievance.

Patient Name *(please print)*

_____ Date:_____

Signature

_____

Acceptance of Appointment

(To be completed by the Representative)

I accept the above appointment.

Representative Name *(please print)*

_____

Relationship to Patient *(family member, friend, social worker, attorney, etc.)*

_____

Representative Signature

_____ Date:_____

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