



# Patient Grievance Form

To request assistance in resolving a concern with your dialysis provider, please complete the below forms and return them to your ESRD Network. To find your ESRD Network, visit [www.ESRDNCC.com](http://www.ESRDNCC.com).

## 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 by 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

Your ESRD Network 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 your Network to use your name, the Network 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 your ESRD Network.

YES, I give permission to my ESRD Network 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 your ESRD Network or The Department of Health Services for your state immediately.

Please visit [www.ESRDNCC.com](http://www.ESRDNCC.com) to find your ESRD Network.

Please visit [www.HealthFinder.gov](http://www.HealthFinder.gov) for information on your state Department of Health Services.



# 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 my ESRD Network 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: \_\_\_\_\_