



FOR PROVIDERS.
BY PROVIDERS.

ACHC COMPLAINT INVESTIGATION INTAKE FORM

HOME HEALTH, HOSPICE & PRIVATE DUTY

STEP #1

Complainant Information Complaint Intake Date:	
Complainant Name:	_____
Patient/Client Name:	_____
Relation to you:	_____
Street Address:	_____
City/State/Zip Code:	_____
Main Phone Number:	_____
Cell Phone Number:	_____
E-Mail Address:	_____

Insurance
Primary Insurance:
Secondary Insurance: <i>(Example: private insurance, Medicare, Medicaid – N/A if no insurance coverage)</i>

Provider Organization Contact Information	
Provider Name:	_____
Street Address:	_____
City/State/Zip Code:	_____
Contact Name:	_____
Main Phone Number:	_____

Witness/Other Contacts

Witness Name: _____

Relevance to Complaint: _____

STEP #3

Consent to ACHC Investigation

ACHC's Accreditation Standards define procedures for the delivery of health care services. Our Accreditation Standards incorporate standards from state and federal laws and the health care industry. After receiving your Complaint, ACHC will conduct an initial review and assessment to determine if your Complaint involves a potential violation of the ACHC Accreditation Standards. After this initial review and assessment, ACHC will inform you whether we have decided to start an investigation, and we also will inform you of the result of our consideration of your Complaint.

Other than disclosures to government agencies, ACHC will not disclose the names of Complainants, Patients, or Witnesses unless permission is given in the form below. However, Provider Organization's detailed investigation and corrective actions regarding your complaint may provide clues as to these identities. Therefore, while we honor all requests not to divulge particular names, ACHC cannot guarantee anyone's anonymity.

You acknowledge that all the information provided is true to the best of your knowledge and that ACHC has your express permission to disclose your identity. Does ACHC have your permission to disclose your identity as Complainant and also to disclose the identity of each Patient and Witness that you have identified on this form? [If you do consent, please check YES. If you do not consent to disclosure of ALL identities, then please check "No," and list those identities that you agree may be disclosed in the space provided below.]

Name Release: Complainant Name: Yes No
Patient Name: Yes No
Witness Name: Yes No N/A
Names that may be disclosed:

Signature: _____

Date: _____

Time: _____

NOTE: Any information sent over the Internet without encryption is generally not secure. Thus, if you submit a complaint using standard e-mail, ACHC cannot guarantee the security or confidentiality of your e-mail transmissions. You take full responsibility if your complaint message is intercepted or accidentally sent to the wrong address.