

# SpiriTrust Lutheran LIFE

## Grievance Form

Report ID#:

Initials of Submitter:

Date:

Participant Name:

County:

Entity/Person Expressing Grievance:

Phone:

Origin of Grievance:

Family/S.O.

Referral Source

Other:

Participant

Spiritual Contact

Physician

Other Provider

Date Reported:

Date of Event:

Date of Response to Grievance:

By Whom?

Nature of Grievance:

Amount of Care Provided

Medical Supplies

Communication

Seeking missing property

Dietary

Transition of Care (i.e. hospital to home, rehab)

Disenrollment Planning

Other:

Medication Concerns

Grievance received via:

Email

Phone call

In person

Website entry

In writing

Services Involved:

Details of grievance, including what, where, whom and when events occurred:

Grievance Acknowledged by:

Date:

(LIFE Staff Member)

If you are not satisfied with the resolution, please refer to your LIFE Enrollment Agreement for the review process.