Patient Grievance Form

To request assistance in resolving a concern with your dialysis provider, please complete the below forms and return them to the Network via mail or fax. Please call the Network if you have any questions.

HSAG: End Stage Renal Network (ESRD) Network 17
3000 Bayport Dr. Suite 300
Tampa, FL 33607
Phone: 800.232.3773 | Fax: 415.897.2422

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.)*

This material was prepared by HSAG: ESRD Network 17, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy nor imply endorsement by the U.S. Government. CA-ESRD-17G091-12072020-01

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:*_____

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Consent to Disclose Patient Identity

HSAG: ESRD Network 17 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 17 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:

HSAG: ESRD Network 17
Patient Services Department
3000 Bayport Dr. Suite 300
Tampa, FL 33607

☐ YES, I give permission to Network 17 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 17 at 800.232.3773 or the State Survey Agency immediately. Please see the enclosed document for the contact information for the State Survey Agencies in the ESRD Network 17 service area.

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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 17 and will act on my behalf regarding 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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Red 17 de ESRD Survey Agencies: Licensing and Certification (Regulatory)

Chico District Office

Counties Served	Butte, Colusa, Glenn, Lassen, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yuba		
Address	126 Mission Ranch Blvd. Chico, CA 95926		
Telephone	530.895.6711 or 800.554.0350	**Fax**	530.895.6723

CMS Region 9

Counties Served	California, Hawaii, Guam, Samoa Americana, Saipan (also Arizona and Nevada)		
Address	90 7th Street, Suite 5-300, San Francisco, CA 94103-6706		
Telephone	415.437.8096	**Fax**	415.437.8004

East Bay District Office

Counties Served	Alameda, Contra Costa		
Address	850 Marina Bay Parkway, Building P, 1st Floor, Richmond, CA 94804-6403		
Telephone	510.620.3900 or 866.247.9100	**Fax**	510.620.3924

Fresno District Office

Counties Served	Fresno, Kings, Madera, Mariposa, Merced, Stanislaus		
Address	285 West Bullard, Suite 101, CA 93704		
Telephone	559.437.1500 or 800.554.0351	**Fax**	559.437.1555

Redwood/Santa Rosa District Office

Counties Served	Napa, Solano, Marin, Sonoma, Humboldt, Lake, Del Norte, Mendocino		
Address	2170 Northpoint Parkway, Santa Rosa, CA 95407		
Telephone	707.576.6775 or 866.784.0703	**Fax**	707.576.2418

Sacramento District Office

Counties Served	Alpine, Amador, Calaveras, El Dorado, Placer, Sacramento, San Joaquin, Tuolomne, Yolo		
Address	3901 Lennane Drive, #210, Sacramento, CA 95834		
Telephone	916.263.5800 or 800.554.0354	**Fax**	916.263.5840

San Francisco District Office

Counties Served	San Francisco, San Mateo, Santa Clara (Cupertino, Los Altos, Mountain View, Palo Alto, Stanford, Santa Clara, Saratoga, Sunnyvale)		
Address	150 North Hill Drive, #22, Brisbane, CA 94005		
Telephone	415.330.6353 or 800.554.0353	**Fax**	415.330.6350

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San Jose District Office

Counties Served	Monterey, San Benito, Santa Clara, Santa Cruz, San Jose		
Address	100 Paseo de San Antonio, #235, San Jose, CA 95113		
Telephone	408.277.1784 o 800.5554.0348	**Fax**	408.277.1032

State of California Department of Public Health

Address	P.O. Box 997377, MS 3001, Sacramento, CA 95899-7377
Toll-Free	800.236.9747

State of Hawaii Department of Public Health

Address	601 Kamokila Boulevard, Room 395, Kapolei, HI 96707
Office of Healthcare Assurance	808.692.7420
Medicare Section Fax	808.692.7447

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