DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID/CLIA COMPLAINT FORM

Control Number:

PART 1 - TO BE COMPLETED BY COMPONENT FIRST RECEIVING COMPLAINT (SA or RO)

1. Medicare/Medicaid/CLIA Identification Number

2. Facility Name and Address

3. Date Complaint Received (M M D D Y Y)

4. Receiving Component
1. State Survey Agency (SA)
2. RO

5. Date Acknowledged (M M D D Y Y)

6.A. Source of Complaint
1. Resident/Patient/Family
2. Ombudsman
3. Facility Employee/Ex-Employee
4. Anonymous
5. Other

6.B. Total Number of Complainants

7. Allegations

7.A. Category

1. Resident Abuse
2. Resident Neglect
3. Resident Rights
4. Patient Dumping
5. Environment
6. Care or Services
7. Dietary
8. Misuse of Funds/Property
9. Certification/Unauthorized Testing
10. Proficiency Testing
11. Falsification of Records/Reports
12. Unqualified Personnel
13. Quality Control
14. Specimen Handling
15. Diagnostic Discrepancy/Erroneous Test Results
16. Fraud/False Billing
17. Fatality/Transfusion Fatality
18. Other (Specify) _____

7.B. Findings (To be completed following investigation)
01 Substantiated
02 Unsubstantiated/ Unable to Verify

7.C. Number of Complainants Per Allegation

8. Action (if multiple actions, indicate earliest action)
1. Investigate within 2 working days
2. Investigate within 10 working days
3. Investigate within 45 days
4. Investigate during next onsite
5. Referral (Specify) _____
6. Other Action (Specify) _____
7. None

PART II - TO BE COMPLETED BY COMPONENT INVESTIGATING COMPLAINT (SA or RO)

9. Investigated by
1. SA
2. RO
3. Other (Specify) _____

10. Complaint Survey Date (M M D D Y Y)

11. Findings (Record under Item 7B above)

12. Proposed Actions Taken by SA or RO
1. Recommend Termination (23 day)
2. Recommend Termination (90 day)
3. Recommend Intermediate Sanction
4. POC (No Sanction)
5. Fine
6. Denial of Payment for New Admissions
7. License Revocation
8. Receivership
9. Provisional License
10. Special Monitor
11. Directed POC
12. Limitation of Certificate
13. Suspension of Certificate
14. Revocation of Certificate
15. Injunction
16. Civil Monetary Penalty
17. TA & Training for Unsuccessful PT
18. State Onsite Monitoring
19. Suspension of Part of Medicare Payments
20. Suspension of All Medicare Payments
21. None
22. Other (Specify) _____

13. Date of Proposed Action (M M D D Y Y)

14. Parties Notified and Dates
1. Facility
2. Complainant
3. Representative
4. Other (Specify)

Party / Date (M M D D Y Y)

15. Date Forwarded to CMS RO or Medicaid SA (MSA) (Attach CMS-2567) (M M D D Y Y)

PART III - TO BE COMPLETED BY COMPONENT TAKING FINAL CLOSE-OUT ACTION (RO/MSA)

16. Date of CMS RO/MSA Receipt (M M D D Y Y)

17. CMS RO/MSA Action
1. None
2. Termination (23-day)
3. Termination (90-day)
4. Intermediate Sanction
5. Move Routine Survey Date Forward
6. Limitation of Certificate
7. Suspension of Certificate
8. Revocation of Certificate
9. Injunction
10. Civil Monetary Penalty
11. Cancellation of Medicare Approval
12. TA & Training for Unsuccessful PT
13. Other (Specify) _____

18. Date of Final Action Signoff (M M D D Y Y)

MEDICARE/MEDICAID/CLIA COMPLAINT FORM

A. General. The complaint form is used to collect basic facility specific information about substantiated and unsubstantiated Medicare, Medicaid or CLIA complaints in order to monitor continual compliance of individual facilities as well as overall State Agency (SA) performance. This form is only to be used if the allegations reported could result in the citation of a Federal deficiency. The form is only to be completed for complaints that are investigated by an onsite visit to the facility. The form must be initiated by the SA or CMS regional office (RO) for any reportable allegation (i.e., related to Medicare, Medicaid or CLIA requirements).

This form is divided into three parts. Part I is completed by the component through which the complaint originated (either RO or SA). Part II is completed by the component actually investigating the complaint (usually the SA). Part III is completed by the component taking the final certification action (RO or Medicaid State Agency (MSA)).

B. Instructions for completing form:

Item 1 – Enter the 6 or 10 digit identifying provider/supplier number.

Item 2 – Enter facility name, address and city/state.

Item 3 – Enter date the complaint allegation was received.

Item 4 – Enter code for component initiating this form.

Item 5 – Enter date of written or telephone acknowledgement of complaint.

Item 6 – A. Enter code that best describes the complaint source (maximum of three sources may be entered).

B. Enter the total number of persons reporting complaints.

Item 7 – A. For each allegation (No. 1 – 5) enter the category code most descriptive of the problem (maximum of five allegations may be entered).

B. Following investigation, indicate finding appropriate to each allegation reported.

Substantiated – An allegation that results in the citation of a Federal deficiency related to the allegation.

Unsubstantiated – An allegation that surveyors could not find sufficient evidence to conclude that a Federal certification deficiency related to the allegation exists.

C. Enter the number of complainants for each allegation reported.

Item 8 – Enter one action code describing the first action taken for any or all allegations (only one code may apply).

Item 9 – Enter appropriate code for investigating agency.

Item 10 – Enter date the first onsite visit was completed in response to allegation(s).

Item 11 – Following investigation, findings for each allegation should be recorded in Item 7B.

Item 12 – Enter proposed actions taken by SA or RO as a result of investigation findings (maximum of three proposed actions may be entered).

Item 13 – Enter date of sign-off of the earliest Item 12 action.

Item 14 – A. Enter code for each party notified (maximum of three parties may be entered).
B. Notification date for party in column A.

Item 15 – Enter date forwarded to CMS RO or MSA. Attach CMS-2567 (Statement of Deficiencies and Plan of Correction) if complaint is substantiated.

Item 16 – Enter date of CMS RO or MSA receipt.

Item 17 – Enter code of final action by CMS RO or MSA (only one action may apply).

Item 18 – Enter date CMS RO or MSA action was signed.