COMPLAINT/GRIEVANCE FORM

This form is to be used for complaints/grievances regarding Community Care Foster Family Homes (CCFFH), Case Management Agencies (CMA) and Community Ties of America (CTA). Please complete the form as completely as possible.

Read the following to all persons filing complaint/ grievance.

CTA does not accept anonymous complaints under current due process laws. CTA requires a name and contact information for a complaint to be accepted. CTA will protect the identity of the complainant who wish to remain confidential to the maximum extent possible by law. Complainants are not able to withdraw complaints once CTA receives the information. Under due process of law, any complainant may be called to testify as a witness in any legal hearing or court should the resolution of the complaint result in an adverse action against the service provider.

CTA does not investigate the following: 1) Allegations of abuse, neglect, mistreatment, and financial exploitation. These will be referred to APS. 2) Financial. These will be referred to the client's CMA, health plan, or legal advisor. 3) Personality conflicts, ethics, or professional behavior. These will be referred to the proper license board, if applicable, and the DCCA. 4) Misuse of client's Medicaid funds. These will be referred to Medicaid Fraud. 5) Unlicensed activity. These will be referred to DOH. 6) Requests for medical records. These will be referred to the client's CMA. 7) Criminal activity will be referred to law enforcement. 8)CNA certification complaints will be referred to Prometrics. 9)CTA has no involvement in the referral or admission process and these will be referred to the client's Medicaid Health Plan, if applicable.

Name of Individual(s)/Agency/Home this Complaint is about: (*address/phone number, if known*)

Name of alleged perpetrator: _____

Address: _____

Phone Number(s): _____

Names and Date of Birth of Clients involved, *(if applicable)*:

_____

Name of CMAs involved, *(if applicable)*:

_____

Name, Address & Phone Number of Person Reporting Complaint:

_____

Does the Reporter Wish to Remain Confidential? YES ☐ NO ☐

Reporter's Relationship to Client (*if applicable*): _____

Complainant's email address: _____
You will receive an email at this address to verify your complaint submission.

Describe Complaint in detail (use additional paper if needed)
Date and time of event:

Describe what happened including where, when, how, who was involved and if this has happened before:

What has been done by complainant to try to resolve the matter prior to making this complaint:

Is there evidence and/or witnesses available? If yes, please describe in as much detail as possible.
Please attach any evidence such as supporting documentation or pictures relevant to the complaint.

Has any other agency (DHS, DOH, APS, Ombudsmen, Law Enforcement, hospitals, etc.) been contacted? If yes, who and when. What was the outcome?

SIGNATURE OF INDIVIDUAL COMPLETING FORM *DATE COMPLETED*

RETURN FORM TO:
Community Ties of America, Inc.
500 Ala Moana Blvd, Suite 7400, Honolulu, HI 96813
Phone: 808-234-5380, Fax: 808-234-5470