CUSTOMER SERVICE FORM

Purpose: *This form is to be used by Local Management Entity/ Managed Care Organization (LMEMCO) staff to document customer service issues such as concerns, complaints, compliments, investigations and requests for information involving any person requesting or receiving publicly funded MH/DD/SA services from a LME/MCO or a MH/DD/SAS provider.*

Tracking #: _____

Person reporting customer service issue: **Date:** _____

Name: _____ Phone: H: _____ W: _____ C: _____

Address: _____

Person reporting customer service issue is:

☐ Anonymous ☐ Attorney ☐ Consumer ☐Consumer advocate/representative ☐DMH/DD/SAS staff ☐Family member
☐ Parent/Guardian ☐ DMA ☐ LME/MCO Staff ☐ Provider ☐ Other (specify): _____

If customer service issue involves a client:

Client name: _____ Phone: H: _____ W: _____ C: _____

Address: _____

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female Disability (check all that apply): ☐ MH ☐ IDD ☐ SA ☐UNK ☐N/A

County of Services: _____ Medicaid County: _____ Home LME/MCO: _____ Host LME/MCO: _____

Race/Ethnicity: ☐ Hispanic/ Latino ☐ African American ☐ Caucasian ☐ Native American ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Multi-racial ☐ Unknown ☐ Other

Parent/Guardian: _____ Phone: H: _____ W: _____ C: _____

Address: _____

Funding Source(s): ☐ County Funds ☐ Health Choice ☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ State Funds ☐ Self-Pay

Customer service issue was received via:

☐ Call ☐ Customer Service Form ☐ Email ☐ Fax ☐ In Person ☐ Website ☐ Written Correspondence
☐ DMA Quality of Care

If issue was referred to the LME/MCO, indicate referral source and specify which LME/MCO or office:

☐ Another LME/MCO ☐ County Office ☐ Provider's Office ☐ DMH/DD/SAS ☐ DMA ☐ DHSR ☐ Other
(Specify): _____

Type of Case: ☐ Complaint/Concern ☐ Compliment ☐ Information/Referral ☐ Investigation | **Priority:** ☐ Routine ☐ High

Nature of primary customer service issue. Issue is related to: (Check only 1 Primary Issue)

☐ Abuse, Neglect, Exploitation	☐ Basic Needs	☐ Provider Choice
☐ Access to Services	☐ Client Rights	☐ Quality of Care
☐ Administrative Issues	☐ Confidentiality/HIPAA	☐ Service Coordination Between Providers
☐ Authorization/ Payment/Billing	☐ LME/MCO Functions	☐ Other (specify): _____

Customer service issue notes: *(Attach additional pages if needed)*

If customer service issue is about a provider or agency: **Provider Category**: ☐ A ☐ B ☐ C ☐ D

Provider/agency name: _____ Phone: _____ Fax: _____

Address: _____

Type/Level of Service: (Check all that apply)

- ☐ Adult Day Vocational Program
- ☐ Ambulatory Detoxification
- ☐ Assertive Community Tx Team
- ☐ Child & Adolescent Day Tx
- ☐ Clinical Intake
- ☐ Community Guide (MCO)
- ☐ Community Support Team
- ☐ Crisis Services
- ☐ Developmental Therapies
- ☐ Diagnostic Assessment
- ☐ Drop-In Center
- ☐ Facility-Based Crisis Program
- ☐ IDD Care Coordination
- ☐ Innovation Services
- ☐ Intensive In-Home Services
- ☐ Long Term Vocational Supports
- ☐ Mobile Crisis Management
- ☐ Medically Supervised or ADATC Detox/Crisis Stabilization
- ☐ Medication Administration
- ☐ MH/SA Care Coordination
- ☐ Multisystemic Therapy (MST)
- ☐ Non-Hospital Medical Detox
- ☐ Opioid Treatment
- ☐ Outpatient Services
- ☐ Partial Hospitalization
- ☐ Peer Support Services
- ☐ Peer Support Service (B3-Only)
- ☐ Psychosocial Rehabilitation
- ☐ Psychological Evaluation
- ☐ Psychiatric Services
- ☐ Residential Services (Category)
- ☐ Respite (MCO B3 Only)
- ☐ Respite
- ☐ Screening, Triage and Referral
- ☐ Sheltered Workshop
- ☐ SA Intensive Outpatient
- ☐ SA Comprehensive Outpt. Tx
- ☐ SA Non-Medical Community Residential Tx
- ☐ SA Medically Monitored Community Residential Tx
- ☐ SA Halfway House
- ☐ Social Setting Detoxification
- ☐ Supported Employment
- ☐ Not Service Related
- ☐ Unknown/ Not Known
- ☐ ☐ Other: _____

Is the Provider Licensed? ..... ☐ Yes ☐ No ☐ Licensing Agency: ☐ DHSR ☐ DSS

Residential

Is Residential an issue in the complaint? ☐ Yes ☐ No **Was consumer involved in DOJ settlement?** ☐ Yes ☐ No

Residential Type:

- ☐ Own home
- ☐ Parents'/ Guardian's Home
- ☐ Therapeutic Foster Care
- ☐ Supervised Living A (Adult with Mental Health Concerns)
- ☐ Supervised Living 5600 B (Minor with Intellectual/Developmental Disabilities)
- ☐ Supervised Living 5600 C (Adult with Intellectual /Developmental Disabilities)
- ☐ Supervised Living 5600 D (Minor with Substance Abuse Concerns)
- ☐ Supervised Living 5600 E (Adult with Substance Abuse Concerns)
- ☐ Supervised Living 5600 F (Alternative Family Living)
- ☐ Unsupervised Alternative Family Living
- ☐ PRTF (Question Below)
- ☐ Level III
- ☐ Family Care Home
- ☐ MH Apartment - Supervised
- ☐ Level IV
- ☐ SA Halfway House
- ☐ Other
- ☐ No Residential Services

If PRTF, Residential Location: ☐ In-State ☐ Out-of-State within 40 mile radius ☐ Out of State outside of 40 mile radius

Did the person discuss the issue with the provider/agency? ..... ☐ Yes ☐ No

Did the person give permission to use his/her name during discussion about this issue with the provider/agency? ☐ Yes ☐ No

Action taken by LME/MCO:

- ☐ Shared the customer service issue with the provider/agency/person(s) involved.
- ☐ Provided the information requested.
- ☐ Facilitated informal discussion/resolution with the provider/agency involved.
- ☐ Facilitated informal discussion/resolution within the LME/MCO.
- ☐ Provided information on how to initiate a Medicaid appeal or LME/MCO complaint process.
- ☐ Conducted Investigation. Person(s) investigating concern: _____

Concern was: ☐ Substantiated ☐ Partially Substantiated ☐ Not Substantiated.

Based on findings: ☐ No further action needed ☐ Recommendations provided ☐ Corrective Action Plan ☐ Other Actions

Date report of findings issued: _____ Number of days from date received until report of findings issued: _____

Date Plan was received: _____ Plan was: ☐ Accepted ☐ Returned For Revision

Date Plan was resubmitted: _____ Resubmitted Plan was: ☐ Accepted ☐ Not Accepted

Date of Follow-up review: _____ Corrective actions were: ☐ Successful ☐ Unsuccessful

☐ Referred to: ☐ DHSR ☐ DMH/DD/SAS ☐ DMA ☐ DSS ☐ Licensing Board ☐ Other (Specify) _____ Date: _____

For: ☐ information ☐ action (specify): _____

Summary Of Issue(s), Investigation, and Actions Taken *(Include dates) (Attach additional pages if needed)*:

Final Disposition: [Action(s) taken include dates]

Resolution

Issue(s) was(were): ☐ Resolved/Completed ☐ Partially Resolved ☐ Unresolved

Resolved by: ☐ LME/MCO ☐ DHSR ☐ DMH/DD/SAS ☐ DSS ☐ DMA (includes Program Integrity)

☐ Licensing Board ☐ Pending

Outcome of Complaints that were NOT Investigated:

☐ Information or technical assistance was provided to complainant

☐ Worked with Provider for Resolution

☐ Referred to Community Resource or Advocacy Group

☐ Referred to External Licensing or State Agency

☐ Referred to Another LME/MCO for resolution

☐ Mediation with parties

Resolution was Appealed:

☐ N/A

☐ 2nd Level Review to Client Rights Committee

☐ 2nd Level Review to LME/MCO Director

☐ Provider Appeal Panel

Number of **Calendar Days** from Receipt to Completion: _____

Number of **Working Days** from Receipt to Completion: _____

Date Resolved: _____

Written feedback of final disposition/resolution was provided to:

Person completing this form:	**Date:**