**COMPLAINT/INCIDENT TRACKING AND RESOLUTION FORM**

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| Date and time of initial contact to BHSB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ BHSB staff receiving initial call:  |
| Complainant/incident reporter name & contact information: Address: Email Address: Phone: Fax: |
| Client name & contact information **(if different than complainant)**: Address: Email Address: Phone: Fax: |
| Client: **🗌** Insured **🗌**Uninsured **🗌** N/A Provider: BHSB Funded Yes **🗌**  No **🗌** |
| Provider Name:  |
| Provider Address: Provider Telephone Number: |
| Has the person filing the complaint utilized the agency grievance procedure or contacted the program? |

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| I. Description of complaint/incident (including dates, times, and all persons involved) Date:  |
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**Triage staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff responsible for follow-up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| II. Action taken by BHSB (including dates, times, all persons involved, and outcomes) Date: |
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| III. Provider response Date: |
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| IV. Complaint/incident resolution follow-up (if applicable) Date:  |
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| Action required i.e. Correction Action Plan, Policy Revision, etc. Date due: |
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***CQA Staff:***

**🗌 Program Lead Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**🗌 Supervisor Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**🗌 Director Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**🗌 Vice President Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**🗌 Recorded on Complaint Log Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**